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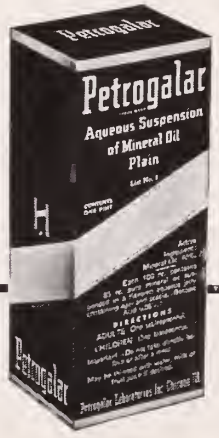
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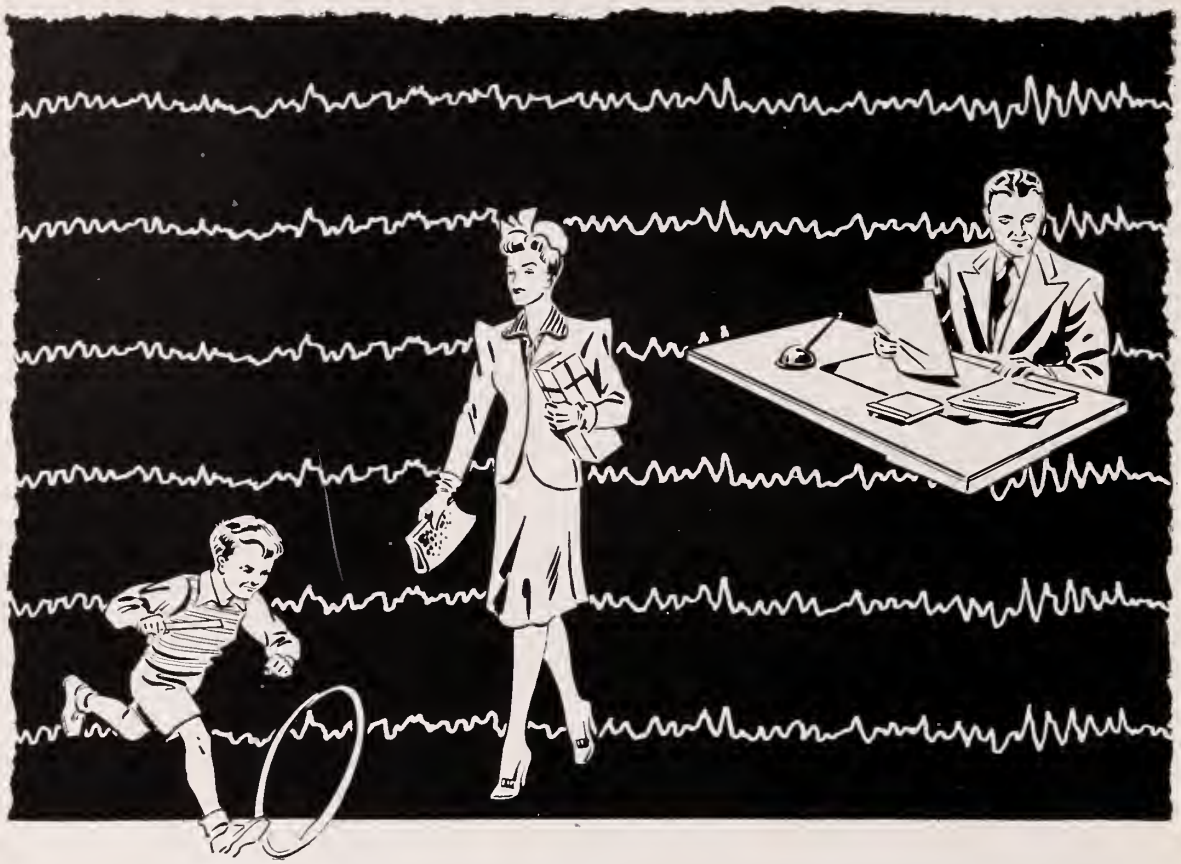
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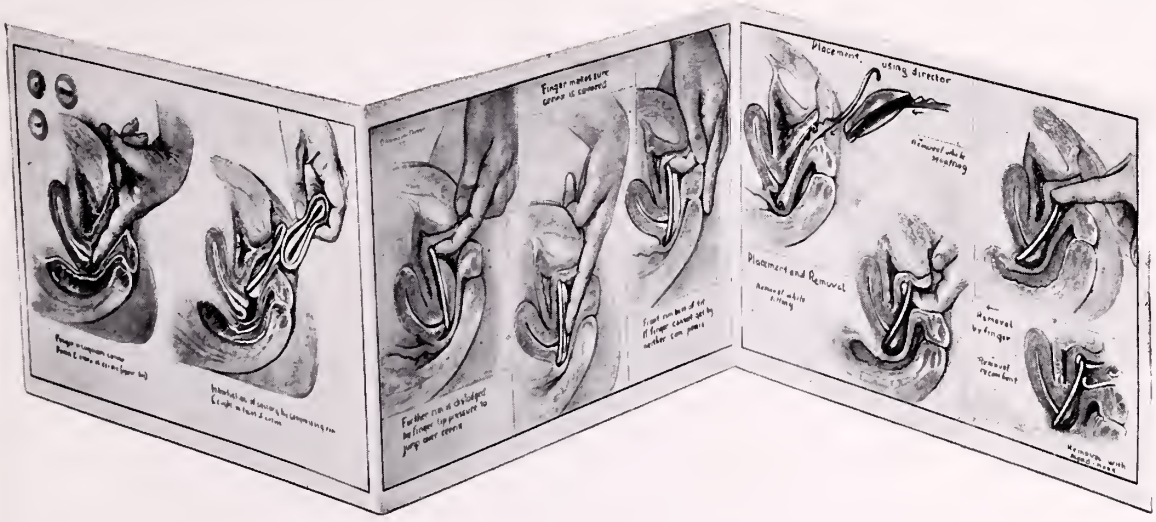
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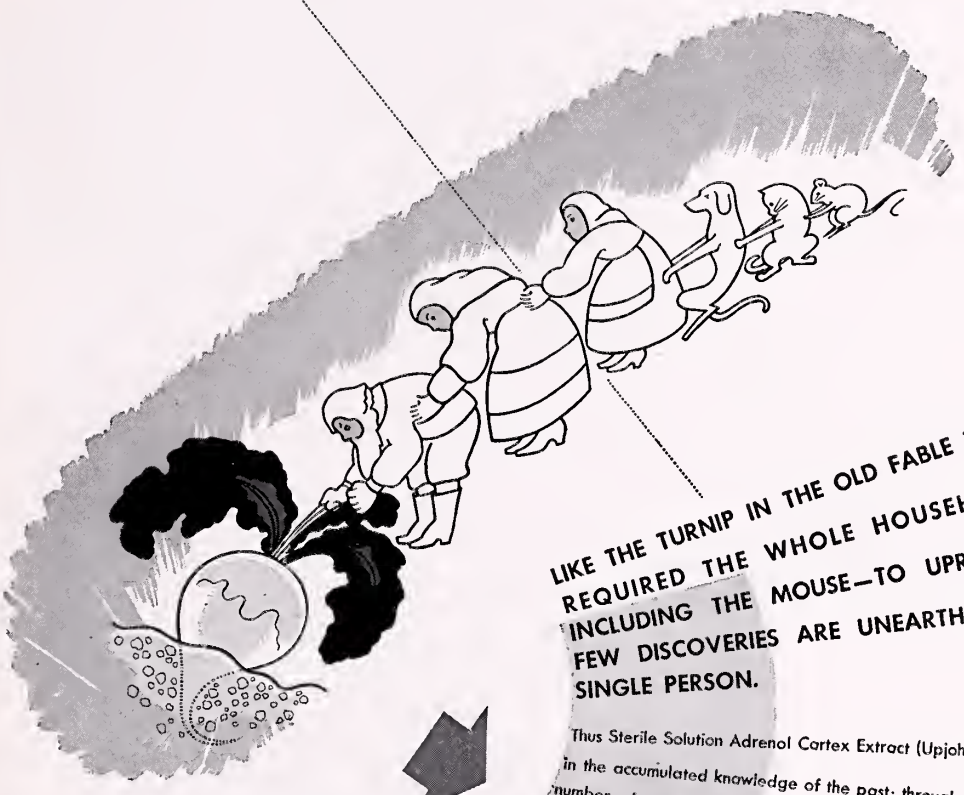
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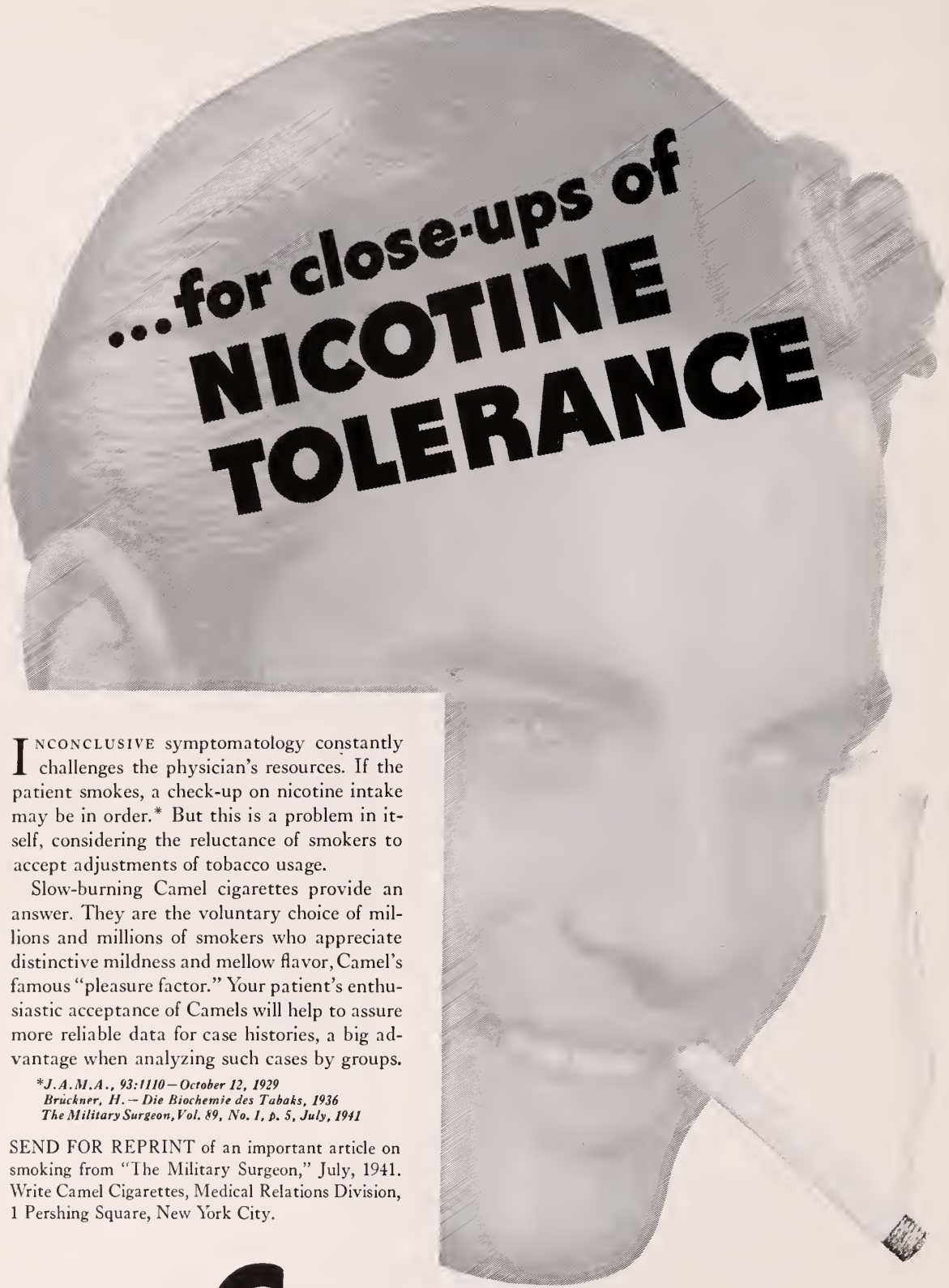
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THE RHODE ISLAND MEDICAL JOURNAL

Volume XXVI JANUARY, 1943 Number 1

ACUTE ANTERIOR POLIOMYELITIS

A Brief Review

K. K. Gregory, M.D.

The mortality rate in acute anterior poliomyelitis in an epidemic is between seven and ten per cent. There are many diseases in which the mortality rate is above this and yet poliomyelitis is still one of the most dreaded of diseases. The loss of a loved one in death is cause for great sorrow, but time soon comforts and heals the aching heart. In poliomyelitis, the deformed, maimed bodies and the life-long helplessness of the victims are a constant source of heart-ache and pity, to say nothing of the economic burden both on the family and the community.

It is little wonder, then, that fear grips the hearts of parents when the disease appears in their midst. In an epidemic, this often develops into hysteria. Consequently, this dreaded and so-called mysterious disease has aroused a tremendous amount of interest among scientists as well as among laymen. Extensive studies and research have been undertaken to learn more about the disease and a large amount of money has been expended for the rehabilitation of its victims. Great progress has been made by these efforts, yet much remains to be accomplished. There have been many false leads and false hopes. Nevertheless, notable contributions have been made and among these, the latest, and to my mind the most important, at least from the patient's standpoint, is Miss Kenny's treatment of the symptoms of acute poliomyelitis. Miss Kenny is of the opinion that poliomyelitis will lose much of its damaging effects when her treatment is universally practised. The disease will then be relegated into a minor position in much the same way as typhoid fever has become less important.

History

Poliomyelitis is not a new disease. Records of human bones and ancient engravings indicate unmistakably that the disease existed long before recorded history. The first epidemic of which we have record occurred in England in 1835, as reported by Badlam. In 1840, Jacob Heine, an orthopedic surgeon in Germany, gave us the first clear description of the disease in the acute stage. Fifty years later (1890), Medin of Sweden distinguished the bulbar, ataxic, encephalitic, polyneuritic, and spinal types. He also recognized the disease as occurring both in endemic and epidemic form. Calverly, in 1894, and Wichman, between 1905 and 1911, recognized the non-paralytic or abortive cases, and the latter showed that the disease was infectious and that healthy carriers played an important part in the spread of the disease.

Poliomyelitis is world-wide in distribution and while no region is excepted, it is more common in Northern Europe, Northern United States, Canada, New Zealand, and Australia. Unlike most infectious diseases which are prevalent in cold weather, poliomyelitis reaches high incidence in the late summer and early fall months. However, severe epidemics of the disease have occurred in Norway and Sweden during the winter months. In the United States, the epidemic in 1916 was the greatest, with a total reported cases of 27,363. Epidemics of lesser extent have occurred every two to six years since 1921. The total number of reported cases up through 1937 was 179,369. While this number is not large when compared with other infectious diseases, it is important for it accounts for thirty to sixty per cent of the cripples in the country.

Etiology

The etiology of poliomyelitis is now generally accepted to be a filterable virus. Landsteiner of Vienna is credited with performing the first successful transfer of the disease to an experimental

animal, the rhesus monkey, by the intraperitoneal injection of a cord suspension from a fatal human case in 1908. This work was subsequently confirmed and the etiologic agent found to be filterable through the finest porcelain. Other causal agents were suggested but only the alpha-hemolytic streptococci advocated by Rosenaw, and the "globoid bodies" of Flexner and Noguchi were seriously considered but they have now been satisfactorily excluded by competent investigators in the field. It has been found that there are several different strains of the poliomyelitis virus, probably as many as there are of pneumococci, each with differing degrees of virulence, adaptability, and immunilogic properties.

While much has been learned about the poliomyelitis virus, progress has been necessarily slow. This is due primarily to the inability of the virus to grow either on artificial media or in the usual laboratory experimental animals. Up to three years ago, monkeys, chimpanzees, and living human nervous tissues were the only means for a successful cultivation of the virus. This was a distinct handicap. However, Armstrong of the United States Public Health Service, reported in 1939 that he was able to transfer the Lansing strain of virus to the cotton rat, and subsequently to white mice and then back to monkeys. This discovery was received with enthusiasm by his fellow-workers. It is now possible for the research worker not only to use different strains of the poliomyelitis virus but also to use cotton rats or white mice for research work instead of the hard-to-get and expensive monkeys or chimpanzees.

Neutralization Test

It was found, early in experimental poliomyelitis, that the blood of monkeys which had recovered from the disease possessed specific antibodies which not only neutralized the virus in vitro but also protected well monkeys against intracerebral injection of the virus. Similar immune substances were also found in recovered human patients. This lead to the hope that convalescent human serum might be effective for prophylaxis and treatment. The convalescent serum was given a good trial throughout the country but the initial high hopes fell when statistics showed that there was no difference between the treated and the control cases. Consequently, the use of convalescent human serum has been abandoned by most clinicians. Aycock, who was the first to advocate its use, was the first to abandon it.

Neutralization test studies have been extended in recent years and these have shown that a high percentage of normal human adults, even in tropical and subtropical regions where clinical poliomyelitis cases are rare, carry specific antibodies in their blood. It has also been found that a higher percentage of adults in cities possess specific antibodies than those in rural districts, and that young children have little or none at all. These findings have been interpreted as the result of a subclinical attack of the disease, perhaps in much the same way as subclinical attacks of scarlet fever or diphtheria develop active immunity.

This explanation has not been accepted by all investigators, however, for there are several discrepancies in it. It is known that patients who have recovered from clinical poliomyelitis have, in many instances, a lower titer in the neutralization test than others who have not had the disease. Furthermore, it has been hard for some to accept the subclinical attack of poliomyelitis as the explanation for the high percentage of positive neutralization tests among people in the tropical and subtropical countries where clinical cases of the diseases are rare. This group of authorities has advanced the theory that the presence of immune substances in the blood of adults is the result of maturation and experiments have been undertaken to support this contention. However, the question is not settled. If this latter theory proves eventually to be correct, it may change our entire conception of immunity.

Active Immunity

Active immunity has been obtained in the experimental monkey by the inoculation of either the attenuated virus or sublethal doses of virulent poliomyelitis virus. Brodie and Park, using formalized virus, which had been found non-infectious for monkeys, inoculated 2,300 children. Kolmer, employing a mixture of virus in sodium ricinoleate, which was admittedly infectious for monkeys, inoculated 10,725 children. Three of the children immunized by Brodie and Park and nine of those immunized by Kolmer developed poliomyelitis. This was unfortunate, for while there was no definite evidence that the vaccines had caused the disease in these twelve cases, the circumstances under which they occurred, and the

fact that they developed in localities where poliomyelitis was not present at the time, pointed to the vaccine as the probable source of infection. This has ended, for the present at least, efforts to develop active immunity in the human by these methods.

Pathology

In interpreting the early symptoms of poliomyelitis on the basis of pathology, before the onset of paralysis, two questions are raised. First, is poliomyelitis a generalized infection involving primarily the lymphoid tissues and attacking the central nervous system only secondarily and rarely? Or, second, is the disease strictly an infection of the nervous system with the clinical symptoms the result of the damage done to it?

The first interpretation is the earlier and the one more commonly recognized. It has the support of many able investigators. It is believed that the generalized infection only occasionally involves the meninges and that subsequently the degeneration of the nerve cells in the anterior horn of the cord is secondary to the perivascular round cell infiltration and edema. Damage to the nerve cells is not complete, in many instances, and therefore many of them are restored to full function as soon as the edema subsides. This is the explanation for the prompt and spontaneous recovery of function in a supposedly paralyzed muscle or group of muscles often seen in the acute stage of the disease. In recent years, however, this interpretation of the pathology of poliomyelitis has lost many adherents because detailed experimental studies have shown that the virus attacks the nerve cells directly and early, before extensive perivascular cellular infiltration has taken place. It has also been found that damage to nerve cells is present even in the pre-paralytic stage of the disease. Therefore, the early symptoms of the disease, according to this idea, are due not to generalized infection but rather to infection of the central nervous system, especially the spinal cord.

The pathology in poliomyelitis is confined primarily to the anterior horn cells of the cord and motor nuclei of the medulla. It is believed that the virus has great affinity for the large nerve cells which it attacks and eventually destroys. Degeneration of these cells is probably not due to any toxic products created by the virus but probably is due to interference of the normal cell metabolism by the virus. Specifically just how this process of interference takes place is at present a subject for speculation.

Sources and Modes of Infection

Up to a few years ago, the nasopharynx was accepted, almost universally in this country, as the portal of entry as well as the portal of exit of the poliomyelitis virus. The virus has been recovered from the nasopharynx of acute, convalescent, and abortive cases, and also of contacts. Similar results have also been obtained in monkeys in all stages of the disease, following all routes of injection. It was also found that the rhesus monkey could be infected by the simple instillation of the virus intranasally and only with great difficulty by any other route. Further investigation revealed that the virus was present in the olfactory bulbs of monkeys infected by the nasal route, before it was present in other parts of the central nervous system.

To prove that this was the pathway of the infection, the olfactory bulbs were sectioned and it was found that the monkeys were no longer susceptible to infection by intranasal instillation of the virus. A further proof of this idea was the experiment by which the nasal mucosa was blocked by the application of zinc sulphate and it was successful in preventing the virus from entering the central nervous system after nasal inoculation. These experimental findings brought the conviction, and thereby the conclusion, that the nasopharynx was the portal of entrance as well as the chief channel for the exit of the virus. It was then only a matter of logic to assume that the disease in man was spread by the secretion from the nasopharynx of those harboring the virus and that the susceptibles became infected via the nasal mucosa. This theory of the source and mode of infection seemed foolproof and enjoyed universal acceptance until three or four years ago when it was seriously challenged by the gastro-intestinal portal idea.

The idea that the gastrointestinal tract acts as a reservoir for the virus is not new. Back in 1912, Kling and his co-workers reported the production of poliomyelitis in monkeys by the intraperitoneal injection of filtered washings from the intestines of acute, convalescent, and post-mortem human cases. But these workers failed to follow through and consequently their work was not accepted. The idea was revived in 1937 by the work of Harmon. He was able to isolate the virus from the stool of

human patients with fair success. It should be pointed out that Toomey of Cleveland had been for years one of the chief advocators of this theory. He was not only able to recover the virus from the stools and intestinal washings of patients, but he was also able to infect monkeys by introducing these materials into the intestinal tract by means of balloons which avoided contamination of the nasopharynx.

During the past few years, evidence has been accumulating to show that it is not only twice as easy to isolate the virus from the stools than it is from the nasopharynx of patients and carriers, but also the amount of the virus in the stool is great. It has been estimated that in a 50 gram stool, there are anywhere between 1,000 and 10,000 infective doses for the monkey. This great quantity of virus must enter sewage during an epidemic of the disease. Investigations have shown this to be true in six localities where the disease was prevalent at the time. That poliomyelitis is not a water-borne disease, in the true sense of the word, has been shown by twenty-five post-epidemic tests on sewage in four large cities. All of them were negative.

The gastrointestinal tract as the chief channel for the exit of the virus brings to the fore the suspicion long held by epidemiologists that beaches, rivers, and ponds are in some way connected with the disease because many epidemics have been traced along waterways. These could be polluted by the sewage or, in the case of ponds, by surface drainage. It has been found that patients or carriers may harbor the virus in the intestinal tract for months. This idea of the intestinal excreta being the chief means by which the disease is disseminated fits perfectly with the seasonal prevalence of the disease.

Now, with all these findings indicating the gastrointestinal tract as the chief source of the virus, the question is how the virus gets there. Is the virus, which is multiplying in the nasopharynx, swallowed and then excreted in the stool? Or, is the virus secreted in the gastrointestinal tract, having come from the central nervous system through the lymphatic system, and in like manner to the nasopharynx? Or, is the gastrointestinal tract both the portal of entry and exit, with the virus being brought there in the first place by the ingestion of infected milk, food, or water? If so, how does the virus gain entrance into the central nervous system? It is certainly not through the blood stream because the virus has never been demonstrated in it. Is it via the lymphatic system, as some investigators believe? There are those who contend that the virus is neurotropic and that it first gains entrance into the parasympathetic system, then through the axons of the vegetative nervous system into the spinal cord and brain, where it finally attacks the motor cells of the anterior horn and cortex of the brain. All of these are, however, only speculations at the present time.

Frequency in an Epidemic

Thus a large amount of information has been obtained from experimental work and while it has not solved the entire problem of poliomyelitis, it has helped explain some of the clinical features of the disease. The statement found in some of the old textbooks to the effect that it is seldom that more than one member in a family develops infantile paralysis is erroneous in view of our present knowledge of the disease. What the authors actually meant was that it is seldom that the disease paralyzes more than one member of a family. Poliomyelitis is a common disease during an epidemic. It is more widespread than we have been lead to believe by our former teachings. Clinically, the disease has been classified as abortive, preparalytic or non-paralytic, and paralytic, according to whether the symptoms are merely systemic or are either accompanied by or followed by paralysis.

Diagnosis

The diagnosis of poliomyelitis may be simple or difficult, depending on whether the patient shows evidence of paresis or muscle spasms. The non-paralytic case offers a problem in diagnosis which is very difficult to solve in the absence of an epidemic. However, symptoms of infection of the upper respiratory tract, together with headache, nausea and vomiting, diarrhea or constipation, and moderate fever, occurring in a patient in late summer or early fall are suggestive of poliomyelitis. Spasms of the muscles of the neck and back and an increase in the lymphocyte count of the spinal fluid are presumptuous evidence of poliomyelitis. If an epidemic is present, the diagnosis is more likely to be correct. The diagnosis of the very mild or abortive cases is difficult and often impossible even during an epidemic of the disease. However, under certain circumstances, such as a family epidemic

where a sibling has the disease with paralysis, a diagnosis of abortive poliomyelitis may be made of those in the family who complain of slight sore throat, headache, and slight malaise, with or without gastrointestinal disturbances. Such a diagnosis has been justified by numerous studies showing that in almost all of these cases, the virus has been recovered from the nasopharynx or stool or both, and that the neutralization tests have revealed abundant specific antibodies in their blood.

I shall not discuss the various paralytic types of the disease nor shall I discuss in detail the differential diagnosis except in two diseases, both of which are of virus origin, namely, lymphocytic choriomeningitis and Guillain-Barré Syndrome (polyradiculoneuritis with albumino-cytologic dissociation).

Lymphocytic choriomeningitis is characterized by symptoms and physical signs of meningeal irritation which are indistinguishable from those of purulent meningitis. The spinal fluid cell count is usually higher than that in poliomyelitis and the cells are all lymphocytes. If such a case occurred in the midst of an epidemic of poliomyelitis, it would be almost impossible to diagnose it as such.

Guillain-Barré Syndrome is a disease so much like poliomyelitis clinically that it is difficult to differentiate the two. There is pain, weakness, and incoordination of various muscles of the body. The most important factor in the diagnosis is the spinal fluid. In Guillain-Barré Syndrome, the cell count and sugar are normal, but the protein is high, as much as ten times the normal level. The sugar and protein in poliomyelitis are within normal limits.

Treatment

The treatment of poliomyelitis in the acute stage, as I have already alluded to in this paper, is symptomatic. Passive immunization with the convalescent human or horse serum has been given up by most clinicians. Active immunization has not been found feasible with present methods. Drugs, even the sulfonamides, have been tried without benefit.

Now I come to the treatment which is at present of much interest and of vital importance to all of us,—in fact, to the entire world—namely, Miss Kenny's treatment of acute poliomyelitis. Indeed, this is the main subject of our discussion tonight, and therefore I shall cease now and pass your attention to the next speaker who will tell you of the practical and more interesting part of this subject.

Charles V. Chapin Hospital

KENNY TECHNIQUE FOR INFANTILE PARALYSIS

Excerpts from the
Continuation Course (for Physicians)
at the University of Minnesota

William A. Horan, M.D.

My purpose here this evening is to present to you the Kenny Method of treatment for Infantile Paralysis as presented to us at the University of Minnesota, Center for Continuation Study. The University is in the City of Minneapolis and is the second largest University in the Country. The Center for Continuation Study, at the University of Minnesota, was opened in 1935 and since that time has harbored some 3500 physicians who have taken special courses of one kind or another. When we registered on September 20th, for a Course which was to extend from the 21st to the 26th, we were assigned to quarters that were quite homey, hotel-like, and designed to do away with the College idea of Dormitory Rooms. At the Center we were not restricted in any way, being permitted to come and go as we chose, and we were offered the use of the Dining Room. In fact, it was suggested that we use it, in order that we might discuss amongst ourselves the subject matter of the course. On the first floor of the building was a huge Lounge where we were to meet every afternoon for Tea. Beyond this Lounge was a Conference Room where we met for Lectures and Round Table discussions.

On Monday, the twenty-first, we met in the Lounge for Orientation, which lasted from nine to nine fifty A. M. and at which time we were presented to the Faculty, who are the following:

Miland E. Knapp, Clinical Assistant Professor of Physical Therapy, Director of Department of Physical Therapy.

Marian Denny, Head Technician, Department of Physical Therapy, Gillette State Hospital for Crippled Children, St. Paul.

Herman Kabat, Instructor in Physiology.

J. M. Nolte, Director, Center for Continuation Study.

William A. O'Brien, Director, Postgraduate Medical Education.

John F. Pohl, Clinical Assistant Professor of Orthopedics.

Sister Elizabeth Kenny, Special Guest Instructor, Department of Physical Therapy.

A. V. Stoesser, Associate Professor of Pediatrics.

We were given a schedule, for the days to follow, which included lectures at the Center and visits to various Hospitals. The program was laid out so as to give us a refresher course in Infantile Paralysis, which includes Myelitis, suppurative Myelitis, Acute Anterior Poliomyelitis, Landry's Paralysis (acute ascending paralysis), and Toxic Myelitis. We also had lectures on the Pathological Physiology of Poliomyelitis, by Herman Kabat. The Kenny Method was then explained to us by Dr. Pohl and Sister Kenny and we were permitted to see cases under treatment and to draw our own conclusions.

Since the refresher course of Infantile Paralysis has been ably covered by my colleague, Dr. Gregory, I will endeavor to relate to you the Kenny Method of Treatment for Infantile Paralysis, offered principally by Doctors Pohl and Knapp. Probably the best way to present their views is to use their own words which have been published by the National Foundation for Infantile Paralysis, Inc., sponsors of the course.

Dr. Pohl presented the Kenny Method of treatment by comparing it with the conventional, or Orthodox Method, which is generally known to us. On a blackboard he headed one column the Orthodox and another the Kenny Method. Under the Orthodox we find,

1. The Virus hits the anterior horn cell.
2. There is a flacid paralysis.
3. Treatment is splints in the acute stage and then re-education of muscles and physical therapy to overcome contractures.

In the Kenny Method we have the same pathology.

1. If there is sufficient destruction of the anterior horn cell, we have paralysis. (Sister Kenny does not claim results in the 15% of cases that are known to be definitely paralysed.)
2. The muscles affected present a condition of spasm.
3. The affected muscles become shortened.
4. Coordination is disorganized and incoordination frequently is seen.
5. The patient loses power in the non-affected muscles because the affected muscles are pulling the non-affected muscles from their normal resting place and retaining them in this lengthened position through the unrelaxed spasm in the affected group.
6. The non-affected muscles frequently refuse to contract due to mental alienation.

The Kenny Method can be condensed into,

1. Muscle spasm.
2. Incoordination.
3. Mental alienation.

Muscle Spasm

The term muscle spasm denotes a group of symptoms including fibulary twitching, fassiculation, hyper-ability of the muscle to stretching and a more or less tonic state of contraction of the muscle fibers which frequently cannot be overcome even by great force. Examination of patients acutely ill with Poliomyelitis bring strikingly to the attention that he suffers from something more than weakness of muscle, whether the affected muscles are painful, tender, irritable or in spasm. Probably this acute spasm in the muscle bears an important relationship to the deforming fibrotic changes in the muscles, common in the chronic stages of the disease, when inaffectively treated in the acute stage. It follows that the treatment of Poliomyelitis must begin immediately with the onset of the disease if grevious after effects are to be avoided. If unrelieved, spasm will result in the destruction of muscle tissue and cause permanent changes and deformity. It will also cause changes in the motor system by eliminating or alienating non-affected muscles and will produce incoordination in muscles concerned in joint movement. A spastic muscle becomes short and, contrary to the usual belief, is not a powerful muscle. How do we detect spasm? Principally from observation, abnormal skin creases, and so forth. The hanstrings, gastrocnemeus, back and neck are usually in spasm.

Incoordination

Incoordination, the second of the major symptoms of Infantile Paralysis is principally of two types:

1. That due to the spreading of motor impulses intended for a certain muscle to other muscles or groups of muscles due to such conditions as pain on attempted motion of the involved muscle or inability of that muscle to perform its proper function.

2. That occurring within the involved muscle itself so that ineffective contraction is produced instead of a coordinated rhythmic contraction producing maximum motion as the insertion of the muscle.

Uncontrolled voluntary motion when attempted in the presence of spasm leads to the symptoms of incoordination by the development of abnormal motion patterns and misuse of muscles. Active motion on the part of a patient unless carefully supervised and directed may do great harm, therefore, and lead to difficulties in securing the return of normal function.

Mental Alienation

Mental Alienation, the third of the major symptoms of Infantile Paralysis, is the term used by Miss Kenny to describe a condition in which there is inability to produce a voluntary purposeful movement in a muscle in spite of the fact that the nerve paths to that muscle are intact. This is a physiological block which must be distinguished from the organic interruption resulting from destruction of anterior horn cells by the disease. "Mental Alienation" may conceivably be produced in several ways, the most frequent being the following:

1. A muscle is pulled beyond its normal resting length by its opponent which is in spasm.

2. A muscle may become alienated when pain is produced in its involved opponent by the attempt of such unaffected muscle to contract.

3. The spasm, or its later results, in an affected muscle may be so severe that the braking action or check on the normal opposing muscle may discourage the latter enough to produce "alienation".

4. The disease may produce changes in the nervous system which do not actually destroy the cells or fibers but do cause loss of conduction power and interference with normal neuromuscular active.

Muscles that are nonfunctioning due to "mental alienation" may remain permanently in this state unless treated.

As an example of "mental alienation" not due to Infantile Paralysis, frequently seen by Orthopedic Surgeons, is the inability of some patients to contract the quadriceps after a knee operation or other painful lesion of the joint. Sometimes reeducation is needed for a prolonged period before normal control of the muscle is obtained in these cases.

Treatment

The Kenny treatment should be begun as soon as the diagnosis of Infantile Paralysis is made. The patient is put to bed on a firm mattress with bedboards placed beneath it. A footboard is used which extends from eighteen inches to two feet above the level of the springs, to assist in keeping the bedclothes off the patient's toes. The foot board is propped away from the end of the mattress by four inch wooden blocks. The purpose of the footboard is to allow the patient to maintain the normal standing reflexes during his stay in bed and it is not in any sense a splint. The mattress is separated from the footboard so that the heel can rest against the board when the patient is lying on the back, and so toes can project below the mattress when he is lying on his abdomen. The patient is placed in bed in a position as closely approximating the normal standing position as possible with the body straight, the arms at the sides and the legs in a straight line. A folded towel or small pad may be used under the knees to prevent hyperextension. If spasm is severe, modifications of this position may be necessary to allow relaxation of the spastic muscles. For example, with a severe spasm of the back causing hyperextension of the spine, the patient may be placed on the abodmen with a pillow under the chest and under the pelvis, or on the back with a pillow in the lumbar region to exaggerate the deformity and thereby allow relaxation of the muscles involved. If there is active spasm in the posterior calf muscles, the foot is not put in contact with the footboard until the spasm has been relaxed.

Spasm

As soon as spasm is diagnosed, treatment should be started by the use of hot fomentations which are prepared in a manner somewhat different from the usual procedure. Woolen cloths such as old blankets are cut to fit the parts accurately so that there will not be too much bulk by folding, but so that there are two thicknesses over each area to be treated. A light waterproof covering is used and around this a piece of dry woolen material of appropriate size and shape is wrapped and pinned in position. These outer coverings are spread out and placed accurately in position under the area to be treated before the hot flannel is removed from the container.

The foments are boiled and wrung from the boiling water twice through a very tight wringer at the bedside so that as much water as possible is removed. They are then applied directly and as quickly as

possible on the part so as to minimize any chance for cooling. It is well to use old wool for the wet packs because new wool seems to be more irritating to some patients. It is unnecessary to protect the skin with ointments although some patients show sensitivity to the application of wet heat by a skin rash but burns should not occur. The packs are placed accurately over the entire muscle and care should be taken to make them of adequate size since the wool tends to shrink from boiling. Joints should not be covered by the packs because of the resultant limitation of motion and increased difficulty of treatment unless the involved muscle itself cover a joint, as for example, the Deltoid covering the shoulder joint. In the hand and foot, of course, joints are necessarily covered because of the small area involved. The packs do not in any way constitute splints and they must not give the patient any sense of fixation. They are renewed usually every two hours, but may be applied as often as every fifteen minutes when the spasm is unusually acute or threatens the life of the patient, as in the involvement of the muscles of respiration. In such a case the wet packs may be used without covering. The packs are continued uninterruptedly being changed as indicated throughout twelve hours of each day. The alternate heating and cooling of the parts as accomplished by these packs seems to be the factor which tends to overcome spasm.

Passive motion through the range that can be obtained without pain is carried out at least once a day but care should be taken not to aggravate spasm by too frequent examination. The Kenny technic does not permit muscle testing or the use of respirators. Muscle testing, which incidentally has never been accurate in the acute stage of Infantile Paralysis, is definitely dangerous because of the likelihood of exaggerating spasm, or of producing incoordination and "alienation". The respirator is not used because its mechanical action in pulling on the ribs tends to aggravate the spasm in the intercostal muscles and because the treatment in the cases in which spasm as the cause of respiratory difficulty should be by hot foment. In cases in which the higher centers are involved are not benefited by either treatment, and may be definitely damaged by the use of the respirator.

Muscle Reeducation

The Kenny method of muscle reeducation is based on the symptoms and concept of the disease previously described.

First, it is assumed that nerve cells are not permanently or completely destroyed until failure of the muscles supplied by those cells to respond to treatment indicates the destruction has occurred.

Second, in addition to anterior horn cell destruction the lack of function is considered to be also the result of loss of connection with the central nervous system either through "mental alienation" by which the impulse is suppressed, or through incoordination by which the impulse is diverted to other channels, or both.

The purpose of reeducation is to restore connection of the part with the central nervous system, (to restore "mental awareness"). Muscle strength is not a primary consideration but the restablishment of "awareness" and the production of a normal rhythmic motion, no matter how weak, is the aim of the treatment. Increase in muscle strength will follow. Muscle testing in the form of attempts to determine muscle strength by isolated action of individual muscles is avoided because of the danger of producing or increasing incoordination and "alienation" as well as spasm.

The neuromuscular system is highly specialized. Although each muscle has a definite primary action, which is a direct pull upon its insertion, it rarely acts alone because of the integration and cooperation of the adjacent muscles. When a joint is moved in any specific direction a number of related muscles come into play. However, there is usually one muscle which is primarily responsible for any given motion and this muscle can be known as the prime-mover of the joint in that particular direction. One must also remember that for each motion performed by a muscle there is an opposite motion performed by an opposing muscle and that the effective function of a joint depends upon the orderly regulation of these opposing units by the controlling nervous system.

When a flexor begins to contract the extensor must simultaneously elongate in a graduated manner so that smooth action of the joint results. The elongating muscle must retain at all times a certain amount of tonus so as to be able to contract imme-

diately and reverse the joint motion. This harmonious action which allows a smooth, orderly and effective functioning of muscles is well referred to as coordination. The disappearance of a particular muscle action from the motor scheme, whether due to direct involvement of the innervation of that muscle by the disease, to indirect involvement by "alienation" or some other cause, will result in attempts by the adjacent muscles to substitute for the lost motion with the development of incoordination.

In starting muscle training this substitution of muscle action must be completely removed and prevented. Every mental and physical effort of the patient must be guided to the muscle which is being trained and to that alone. Allowing and even encouraging a patient in the free choice and substitution of muscles for the mere satisfaction of haphazard motion of the joint invites disaster.

Technic of Muscle Reeducation.—As soon as joints can be moved passively through a small range without pain or incoordination indicating that spasm is lessening, muscle reeducation within that range is started with the patient still in bed. At first this consists largely of maintaining or developing a "mental awareness" of the muscles and their insertions. Later, as spasm decreases, the more active reeducation can be added. In the presence of incorrect muscle action such as substitution or incoordination, active motions on the part of the patient are prohibited until passive motions can be carried out by the technician with complete relaxation of the patient. Having achieved this state, voluntary motions on the part of the patient may be instituted but such action is always under the control and guidance of the technician. For this later muscle reeducation the patient is placed on the treatment table in as normal a position as possible. This is considered to be the usual standing position with the arms at the side, the legs in a straight line with the body, the feet at right angles and the knees straight. The patient must be relaxed and cooperative. Reeducation cannot be carried out in babies who are crying, or in children or adults who are fearful of pain or other harm. Therefore reeducation cannot be attempted before painful spasm is eliminated.

Before treatment is started the patient is instructed to lie quiet without using any muscle other than the ones to be treated. His attention must be concentrated solely on the motion to be performed. The technician then firmly grasps the part to be treated and without causing pain carries out the intended motion passively through whatever range is possible without pain. The technician instructs the patient concerning the part to be moved by stroking the exact insertion of the muscle group to be trained. With the patient concentrating on this point of insertion the motion is carried out twice passively and then the patient is instructed to attempt to carry out that motion actively. A muscle, whether paralyzed or "alienated", which is being trained, must be made to contract at least in a mental sense if in no other way; the conscious mind must accept this "awareness" of the muscle if orderly and coordinated action is to be obtained. If any visible or palpable motion is accomplished, the treatment is stopped immediately in order to leave with the patient the memory of the accomplishment. If any muscles other than the one to be trained come into play, the attempted motion is stopped immediately and the unwanted muscles put out of action by instructing the patient to do so or by finger pressure against the muscle. Much care is observed to prevent incoordination, which is shown by this attempt of the patient to bring other muscles into play. Care is taken also not to tire the patient in any way. Treatment must be discontinued if the patient shows evidence of fatigue or is uncooperative for any reason. As the patient learns how to move the muscles, more movements are given, gradually increasing the range and number of motions, although enough work to tire the muscle is never allowed.

If there is no trace of motion in spite of absence of spasm, the proprioceptive reflexes are stimulated by placing the muscle slightly on the stretch and then stimulating the muscle through the tendon by moving the joint backward and forward. This procedure is repeated daily or several times daily even while the patient is receiving hot foments. Miss Kenny has demonstrated that function of that muscle should eventually return if the muscle can be stimulated by this procedure so that the course of the tendon can be followed from its insertion to the muscle belly. "Loss of tendon" which indicates complete loss of muscle tone is an indication of probable permanent and complete loss of function.

Sister Kenny's classification of muscles is,
1. Group One. Muscles that contract within their normal resting length.

Group Two. Muscles that have to be removed from their normal resting length before a suitable contraction can occur to perform their primary action.

Group Three. Muscle group with separate origin and common insertion and multiple action.

Group Four. Muscle groups with dual origin and dual insertion and multiple action.

Group Five. Muscles that stabilize positions obtained by other muscle groups.

The first two are the most important groups.

The biceps of the arm and the hanstrings belong to the first group and the triceps and quadriceps to the second, and one example will show the importance of this classification. The quadriceps, to contract so as to perform its normal action, must first be pulled from its normal resting position by flexion of the knee. Only then can the pull be placed at the insertion of the pattellar tendon and the knee extended. The performance of this motion is the primary function of the quadriceps muscle. So called "setting" of the muscle with the knee extended does not have any place in the Kenny method.

Muscle reeducation, then, depends upon the relief of spasm, the teaching of muscle awareness, the combating of incoordination and "alienation", and the retraining of nerve pathways back to the non-functioning muscles.

Only two positions are used, the spine and prone, and all the anterior muscles are treated before the patient is turned over to allow the posterior ones to be attended.

This outline of the Sister Kenny treatment is from lectures given by Drs. Pohl and Knapp, and writings under their names.

In addition to their lectures we were privileged to listen to Dr. Herman Kabat on pathological Physiology of Poliomyelitis. He told us that when the Sister Kenney method came to the University of Minnesota it was turned over to the Physiologists for an explanation and these gentlemen analyzing both the Orthodox and the Sister Kenny methods of treatment were forced to admit that the Orthodox treatment had no physiological worth or could not be explained from a physiological angle. While the Sister Kenny treatment lent itself admirably to such explanations, he felt that the serious symptoms of Poliomyelitis were almost entirely related to muscle and include

1. Paralysis (irreversible)
2. Physiological contracture (muscle spasm)
3. Reversible Paralysis (Mental alienation)
4. Incoordination
   a. Substitution
   b. Asynergy
   c. Arrhythmia

One of the most interesting recent developments in physiology has been the accummulation of evidence for the humoral theory of transmission at the myoneural junction. With each nerve impulse a small quantity of acetylcholine is released at the myoneural junction, and it is this chemical substance which stimulates the muscle fiber to contract. The acetylcholine causes depolarization of the membrane at this point, producing an end plate potential which acts as an electrical stimulus to the muscle fiber. This acetycholine mechanism is also responsible for excitation at parasympathetic nerve endings and at synapses in automatic ganglia.

Dr. Kabat felt that anterior Poliomyelitis produced a liberation of acetylcholine which caused a contracture. This contracture in turn caused an Ischemia, the Ischemia in turn caused pain and the pain caused a liberation of more acetylcholine completing a definite cycle, which unless interrupted would cause muscle spasm and definite permanent contracture. Another interesting feature of this study was that the hot packs of Sister Kenny have the property of breaking this cycle, by reducing the Ischemia and causing the Hyperemia. This is only one mechanism capable of explaining muscle spasm. He offers two others along similar lines. All three, he took care to say, were entirely speculative but possible. At the lectures, frequently, the whole staff participated. Sometimes they argued amongst themselves over various points at issue. Sister Kenny invariably was present and on one occasion delivered a lecture. This consisted principally of a talk concerning herself and her entrance into the field of Poliomyelitis. It has been told so often that I am not going to take up your time by repeating it.

She was at her best at the Hospital Clinics. We were fortunate in being at Minneapolis at a time when there were many acute cases of Polio. At the University Hospital we had an opportunity to ob-

serve the hot-packs and to see the cases under actual treatment. The situation there was extremely orderly. Each treatment was carried out by expert technicians, the hot packs applied and the muscular reeducation was taken care of by one of Sister Kenny's assistants. A similar situation existed at the Minneapolis Hospital. Here the conditions were not quite so ideal but we had the chance of seeing several acute cases receive immediate treatment. One case was a youngster who had paralysis of the Platysma Muscle. We were there when the child was brought in and saw his condition, with jaw drawn down and unable to swallow or to speak. We again saw the youngster after he had received hot packs for twenty-four hours and were amazed to see that he could both swallow and talk. Sister Kenny had given the child her personal attention throughout the night. One could not help but be impressed with this form of treatment. The youngsters in their acute stage being free from pain, were co-operative and lacked the apprehension that usually goes with the acute stage of Polio. Sister Kenny has mastered anatomy. She knows her muscles, their origin, insertion and particularly their connection with other muscles. She has the ability also to teach and frequently imparts this knowledge to her patients.

One patient was being examined before a group, a particularly likable negro child. Sister Kenny examined the youngster, demonstrating certain muscle groups that she wished to bring to the attention of her audience. The youngster, on being dismissed said, "Sister Kenny, you have not stimulated my Gastrocnemeus muscle." Sister Kenny replied, "And what else haven't I stimulated?" The child then immediately enumerated the various muscles which Sister Kenny had neglected to stimulate. Some people feel that this might be a case of showmanship; still other cases that we saw, while not quite so spectacular show that the youngsters obtain a considerable knowledge of anatomy which must be beneficial in their treatment.

While the results of the Sister Kenny treatment, in the acute stage, are remarkable, Sister Kenny has also obtained some good results in the older cases, although her method is primarily one for the acute case.

During the course we ran into such words as PROPRIOCEPTORS and STRETCH REFLEX, both of which have an important meaning in the Kenny technic. Kreig is responsible for the following: Functional Neuro Anatomy.

The reflex behavior falls into definite named patterns and the individual reflexes may be evoked at the will of the operator by the application of the effective stimulus. The various reflexes will now be reviewed. They should be thoroughly understood as they are the blocks from which the structure of normal postural activity are built.

An example of the simplest reflex is the KNEE-JERK. Like many other of the reflexes to be enumerated the knee-jerk can be elicited in the intact and conscious man. It can be induced by suspending the leg freely and tapping on the patellar tendon. The knee extends quickly, and as rapidly falls back to its original position. An impulse has been received by the nerve endings in the tendon, transmitted up a sensory nerve fiber, through the sensory root of the third lumbar segment, then carried by the sensory collaterals through the gray matter to the motors cells of the ventral horn, in the same segment and on the same side, and finally to the quadriceps muscle, which, contracting, extends the knee.

If the sole of the foot is stimulated by gently placing a flat surface in contact with it, the foot is pushed down on the stimulating surface. This is called EXTENSOR THRUST, because the extensor muscles of the limb are called into action. Its effect is thus the opposite of the flexor reflex. Its object is to enable a firm footing to be made. If all four feet of a mammal be simultaneously stimulated in the manner described the results is a SPINAL STANDING a condition in which the spinal animal supports itself. Spinal standing is an uncertain reaction and is not easily maintained. It will be learned later that the basal part of the brain must be present if effective support is to be obtained. Extensor thrust is diagrammed similarly to the flexor reflex, but the sense organ is a pressure receptor in the sole and the active muscles are the extensors (glutaeus maximus, quadriceps, soleus).

Still another reflex may be induced by a proper stimulataion of the sole of the foot. If a toe be clamped gently in one position the foot will be moved from side to side and the extremity flexed, obviously to free the foot. This is the CLIP REFLEX. It may be diagrammed similarly to the flexor reflex, but additional muscles: adductors and abductors must be added.

The stretching of a muscle, by moving the bone on which it acts in such a manner as to elongate the muscle, or tapping of the muscle's tendon (thereby stretching the muscle), causes that muscle to contract, and to maintain this contraction for as long as the stretching continues. This is the STRETCH REFLEX, an important and fundamental one. It can be shown to be incited by the stimulation of the specialized end-organs within the muscles and tendons. The importance of the stretch reflex and its modifications in the intact animal can hardly be overemphasized. It prevents a limb from being placed in awkward positions and gives a running start, so to speak, to muscular contraction in such movements as walking. It is "posture in the making". Normally the constant activity of the proprioceptive endings in muscles, tendons, and joints induces a state of moderate contraction or TONUS in the postural muscles throughout the body. A very minute elongation of the muscle will induce the reflex. When allowed to draw its own graph, one sees that recruitment of motor neurons is a marked trait, but that after-discharge is absent or greatly reduced. The proprioceptive receptors (PROPRIOCEPTORS) do not adapt to continuous stimuli, so the tonic nature of the contraction will continue as long as does stimulus.

The physicians course in Kenny Technic permitted us to see the clinical picture of patients suffering from anterior Poliomyelitis, requiring hot fomentations to the various parts of their bodies. We also saw the technic of muscle reeducation demonstrated. This was all carried out under ideal conditions in the hospitals in Minneapolis. During these demonstrations Sister Kenny remarked that even poor Kenny treatment was better than no Kenny treatment. Our final hospital visit was to an institution away from Minneapolis. Here the conditions were not as ideal as they were in the hospital we had visited previously due to reasons beyond the control of the hospital management. The children had received either delayed or poor Kenny treatment but in spite of this we were impressed with their improvement. I am sure that we all left Minneapolis for home feeling that Sister Kenny had demonstrated the value of her treatment for the acute cases of Infantile Paralysis.

319 Broad Street

COMBINED MEETING

RHODE ISLAND MEDICAL SOCIETY

PROVIDENCE MEDICAL ASSOCIATION

Medical Library, February 4, 1943,
at 8:30 P. M.

Speakers

Dr. James E. Paullin of Atlanta, Georgia, President Elect, American Medical Association. President, American College of Physicians.

Dr. James C. McCann of Worcester, Mass. Will speak on the Massachusetts Medical Service Plan.

Dr. Herman C. Pitts.
Will speak on the Rhode Island Sickness Insurance Act.

DENTISTS TO HONOR DR. GORMLY

A By-Law of the Rhode Island State Dental Society reads as follows:

> The Rhode Island State Dental Society may each year, at the annual meeting, grant its award, consisting of medal and scroll, to one who through eminent service has promoted the advancement of dentistry or furthered its public appreciation.
>
> Full authority in naming the person to whom the award shall be granted is vested in the Board of Trustees.

Under this By-Law the Trustees have voted the medal of award and scroll of the Society to Dr. Charles F. Gormly, President of the Rhode Island Medical Society. The scroll and award will be presented to Dr. Gormly at the annual dinner of the Rhode Island Dental Society on January 27.



THE RHODE ISLAND MEDICAL JOURNAL
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122 Waterman Street, Providence, R. I.

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OUR OBLIGATION

At this time of War and Rationing, the Medical Profession apparently is preferred above all civilian groups; given *C* cards for extra gasoline (the doctor naming his own needs), *E* markers for the windshield, that he may drive freely in emergency, and tire permits in the earliest classification.

With such privileges come corresponding responsibilities.

If conservation of gasoline, due to tanker shortage, and of rubber, from military needs, are imperative, we doctors must freely cooperate with the lay public in effecting this conservation. Every necessary mile we drive and every mile beyond our professional requirements is so much handicap to a speedy end of the war; conversely, each *C* coupon which we can return, showing gasoline economy, is to the good in furthering this end.

Let's remember that doctors are semi-public characters, respected and observed perhaps more than the average citizen; wherefore, whether or not we like it, we are expected to set an example in all matters bearing upon the war effort. We must maintain our own homes at 65° and use due restraint in signing, for our patients, certificates for extra fuel oil; see to it that our blackout details are correct and follow the laws of rationing to the letter.

In truth, it is our especial business, here at home, to play the war game to the limit, and so to use our not inconsiderable influence in the community that others may do likewise.

ATYPICAL BRONCHO-PNEUMONIA, "VIRUS PNEUMONITIS" OR WHAT?

There is no reason to doubt that upper respiratory infections, endemic and epidemic, mild and not so mild, have afflicted the human race and its evolutionary precursors since their first appearance on the earth. Spirits, devils, miasmas, chilling the body surface with draughts and a multitude of bacterial factors have been considered and discarded as the primary etiological agents as man's familiarity with his environment has increased. Nowadays for many of these conditions an ultra microscopic virus has been found and has been shown to be associated with outbreaks of what are clinically classed as influenza and common colds.

But at present, as every practitioner knows, what seems to be a closely related but distinct disease entity prevails in epidemic, perhaps pandemic, form. This condition has been labelled "virus pneumonia" or "pneumonitis" — "virus", because attempts to isolate a virus have given rise to suggestive but thus far inconclusive results and because of its close resemblance to psittacosis, Q fever and other known virus diseases; and "pneumonia", because in many cases it is possible to demonstrate by X-ray or physical examination pulmonary involvement, usually small but sometimes extensive.

A number of pertinent questions arise. In the first place is this clinical entity new, or have we merely given a new name to a previously prevalent but unrecognized condition? All physicians who have been in general practice since 1918 will remember having seen a large number of cases of "influenza" in which, when the temperature failed to come down, or rose secondarily after the initial attack, cough persisted and vague pulmonary signs

appeared late in the disease. X-rays, when taken, showed "atypical" findings indistinguishable from those seen in the present outbreak. These cases were labelled "influenza with complicating broncho-pneumonia", "post-influenzal pulmonary infection" or given some similar designation and were generally supposed to be due to secondary infection with pyogenic bacteria—as perhaps many of them were. Again, one may ask if the disease as it now exists may be appearing in a new light because common contaminators, especially pneumococci, have been rendered relatively rare by the widespread use of sulfonamide drugs. In other words has the relative suppression of pneumococcus infections uncovered a commonly associated virus infection which now appears by itself as if it were a new condition?

These and other questions must remain unanswered until fundamental studies on the etiological factors have been successfully completed. In the meantime we may say that a condition prevails which from a clinical standpoint at least is somewhat new, which is unaffected by sulfonamide drugs, which appears to have an incubation period of nearly two weeks and whose clinical picture merges into that of influenza and "colds" with so little chance of definite differentiation in many instances as to leave the whole situation confused.

NATIONAL CONFERENCE ON MEDICAL SERVICE

1943 Meeting—Palmer House—Chicago, Illinois
Sunday, February 14, 1943

To the Editor
Rhode Island Medical Journal

The date for the 17th annual meeting of the National Conference on Medical Services has been set for Sunday, February 14. This meeting is held annually in connection with the Congress on Medical Education and Licensure, you will remember, which is scheduled this year for February 15 and 16. The place of meeting will be the Palmer House, Chicago.

We all know that the postwar period will present many critical problems to the medical profession as well as to all other lines of endeavor and that a great deal of legislation with strong socialistic tendencies will unquestionably be introduced into Congress.

In order to meet this situation, a great many feel that medicine should be better represented in Washington than it is at the present time. That there should be a permanent office there, adequately manned, so that reliable information about health can be furnished to the bureaus, Congressmen and Senators as well as the doctors back home. These men feel that this is a proposal of the greatest importance and that it should be our major topic of discussion at the meeting. We solicit your opinion either pro or con on this important matter, together with your suggestions as to people who could take part in the discussion.

Sincerely yours,

W. L. Burnap, M.D.
Secretary

UROLOGY AWARD

The American Urological Association offers an annual award "not to exceed $500" for an essay (or essays) on the result of some specific clinical or laboratory research in Urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years.

The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, May 31—June 3, 1943, Hotel Jefferson, St. Louis, Missouri.

Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 1, 1943.

LESSONS FROM BRITISH EXPERIENCE IN CIVIL DEFENSE

Distributed to Regional Medical Directors by the
Office of Civilian Defense, Washington

Three years of British experience with air raids have significantly modified earlier concepts regarding the field casualty services. The following observations were made on a recent inspection of emergency medical facilities in England and Scotland.

1. Heavy raids occur invariably at night; heavier high-explosive bombs and land mines are now being employed, up to 2,000 kg., with much greater destructive effects. Incendiary bombs are used in much larger numbers, and fire is now the most serious hazard. Daylight raids are usually hit-and-run affairs in which solitary planes participate.

2. In large cities the field casualty services may handle 2,500 to 3,500 casualties during a night raid. All serious casualties are moved directly to hospitals, never to first-aid posts. Heavy raids are apt to be repeated on subsequent nights when the protective forces are exhausted.

3. A large fleet of four-stretcher ambulances is essential for life saving. Fourteen thousand ambulances were made in England and Scotland by purchasing used cars, stripping them, and then mounting a simple ambulance body on the chassis. London uses over 1,500 of such ambulances and 550 sitting-case cars. The use of tradesmen's trucks proved universally unsatisfactory; 3 out of 4 never arrived on the scene, and lives were lost due to the delay and confusion. Because of the large number of casualties to be transported in a few hours, no ambulances which carry less than 4 stretchers are employed. For the simultaneous evacuation of damaged hospitals, a fleet of 200 converted busses carrying 10 stretcher cases and 6 to 10 sitting cases are immediately available, and another 200 are obtainable within 2 hours.

4. Casualty stations (British fixed first-aid posts) are necessary at or near all hospitals and at places more than a mile from hospitals to care for minor casualties which do not require hospitalization. Many are now on a care-and-maintenance basis and are activated only during a raid. When functioning, the staff usually consists of one or two doctors, several nurses, and a variable number of aides and auxiliaries.

5. In large cities casualty stations need not be more numerous than 1 per 25,000 inhabitants; they should be located about a mile apart. There are less than 300 in the London area, with a population of about 10,000,000 and a land area more than twice that of Greater New York. In smaller, thinly settled communities, they are more numerous in relation to population, but the distances between them are proportionately greater than in metropolitan cities. Many of the minor casualties are moved to first-aid posts in sitting-case cars; some walk.

6. First-aid parties (our stretcher teams) are not necessary, are a waste of manpower, and are rapidly being eliminated. First aid at incidents is essentially a function of the rescue parties (our rescue teams), which extricate the casualties from under the debris of demolished buildings. All first-aid parties in England and Scotland are, therefore, being merged into the rescue parties. They include a leader, an assistant leader, and eight other members, and are entirely independent of the fire department. They are a life-saving service related to the medical services concerned in field casualty work.

7. The experiences of Britain under air-raid conditions have dispelled many preconceived notions, concerning first aid. Almost all raids occur at night; the victims are crushed under the debris of demolished buildings and are either dead or severely injured; less than a third are slightly injured and can be cared for at casualty stations; all the severely injured must go to a hospital; victims are invariably covered with dust and dirt which hangs in the air for hours. The conditions under which the rescue workers encounter the injured beneath the structural debris, the darkness and the dust which always fills the air, the large proportion of dead and severely injured, and

the urgent need for immediate hospitalization make it impossible to apply most peacetime concepts of first aid.

8. Wounds are usually grossly contaminated and need only be covered with a shell dressing until the casualty reaches the hospital. Hemorrhage is usually controllable with a pressure dressing. The tourniquet is rarely employed. Burns are covered only with sterile gauze until the casualty arrives at the hospital. Tannic-acid jelly as a first-aid dressing for burns has been discarded because of the dirt which invariably contaminates the burned surface, because the jelly deteriorates rapidly, and, lastly, because tannic acid ignites in the presence of phosphorus when applied to burns caused by the explosion of phosphorus-oil bombs.

9. Traction splints are not used. An exception is made if the casualty must be transported a long distance over country roads. Unlike Army field experience in the last war, the few miles of travel to a hospital over the paved roads of a city do not warrant the application of traction, especially as the darkness and the conditions of an air raid also make hurried application of the procedure difficult or impossible. All that can be done is to place the fractured extremity gently in alignment, bind it with triangular bandages to the uninjured leg or to an improvised splint, or apply a Thomas splint if one is on hand. Movement of the fragments can also be minimized by snug application of the blankets according to the Wanstead technic of blanketing and by the use of sand bags, which should always be carried in the ambulance.

10. Shock is treated at the incident by prompt administration of adequate doses of morphine (up to ½ grain for adults), coramine, proper blanketing, administration of fluids, and the use of hot-water bottles during transportation to the hospital. The use of plasma or blood transfusion is deferred until arrival at the hospital; it is ordinarily quite impossible in the darkness, dirt, and confusion at the incident.

11. The presence of a physician at the incident is invaluable, but more than one is unnecessary. In fact, one physician may cover several nearby incidents, leaving his nurse or one of the nursing auxiliaries of his emergency team at the incident while he moves temporarily from one to another in the immediate neighborhood.

12. Even though a single night's casualties requiring hospitalization may total one or two thousand, large hospitals rarely receive more than 50 to 100, the load being distributed as evenly as possible throughout the city.

13. A large casualty receiving hospital is often related to one or more peripheral hospitals in the suburbs or in a country district. There are now four base hospital beds for each casualty bed in the cities.

14. Upon receipt at a local report and control center of a message from an air-raid warden that an incident and casualties have occurred, an "express party" is immediately dispatched to the scene. An "express party" includes one rescue-first aid party, one ambulance, one sitting-case car, and one mobile medical unit (our mobile medical team). The latter consists of one physician, one nurse, and two auxiliaries. No other equipment and personnel of the emergency medical service is dispatched unless additional assistance is requested by the incident officer (usually a higher police official) or by the incident physician on the scene. In this manner useless movement is avoided and equipment and personnel of the community is carefully conserved.

PROVIDENCE MEDICAL ASSOCIATION

The 96th Annual Meeting of the Providence Medical Association was held at the Medical Library on Monday, January 4, 1943. In view of the large attendance of guests invited to hear the discussion on infantile paralysis the scientific program was presented early in the evening, followed later by the business session which was restricted to members of the Association.

Dr. Kalei K. Gregory presented a paper on "Acute Anterior Poliomyelitis — A Review of Essential Features", after which Dr. William A. Horan spoke on "Some Impressions of the Kenney Treatment". These talks were followed by a demonstration of application of fomentations given by Miss Helen Cahalan and Miss Madeline Bailey. The orthopaedic viewpoint was briefly discussed by Dr. Herbert E. Harris, and the pediatric viewpoint by Dr. Banice Feinberg.

In his presidential address Dr. Henry E. Utter highlighted the work of the Association during the past year, and forecasted some of the future problems of medicine in the light of present social trends.

Following this oration Dr. Utter called for nominations for President of the Association for 1943, and Dr. William P. Buffum moved the nomination and unanimous election of Dr. Emery M. Porter. The motion was adopted and Dr. Porter was declared elected, and was escorted to the rostrum where he spoke briefly on plans for 1943, and announced that his complete list of committee appointments would be announced in the February issue of *Medical News*.

A motion being in order for the nominations of a Vice President, Dr. William M. Muncy moved that the entire slate of officers as recommended previously by the Executive Committee be declared nominated and be elected. The motion was unanimously approved, and the Secretary cast the ballot electing the following slate of officers for 1943:

Vice President ..... Albert H. Jackvony, M.D.
Secretary ..... Frank W. Dimmitt, M.D.
Treasurer ..... Herbert E. Harris, M.D.
Executive Committee (2 members for 5 year terms) ..... Henry E. Utter, M.D.; Frank I. Matteo, M.D.
Councillor to R. I. Medical Society (2 year term) ..... John G. Walsh, M.D.
Trustee of R. I. Medical Library (1 year term) ..... Peter P. Chase, M.D.

Delegates to the House of Delegates of the Rhode Island Medical Society

John A. Hayward, M.D.
Harry C. Messinger, M.D.
Charles L. Southey, M.D.
Henry F. McCusker, M.D.
James Hamilton, M.D.
John G. Walsh, M.D.
Merle M. Potter, M.D.
James H. Fagan, M.D.
Kalei K. Gregory, M.D.
Raymond F. Hacking, M.D.
Ralph Di Leone, M.D.
Joseph B. Webber, M.D.
Frank J. Honan, M.D.
Robert H. Whitmarsh, M.D.
Joseph L. Belliotti, M.D.
George W. Waterman, M.D.
Jerome J. McCaffrey, M.D.
Frank W. Dimmitt, M.D.
Louis A. Sage, M.D.
Gordon J. McCurdy, M.D.
Edward S. Cameron, M.D.
Bertram H. Buxton, M.D.
Harmon P. B. Jordan, M.D.
Harold G. Calder, M.D.
Anthony V. Migliaccio, M.D.
A. Henry Fox, M.D.
Arcadie Giura, M.D.

Dr. Herbert E. Harris, treasurer, read his annual report for the year, which was approved and placed on file.

The new Secretary, having been escorted to the Secretary's desk, presented the report of the Executive Committee making the annual recommendations of appropriations and setting the annual assessment of dues for 1943 for active members at $15. The report of the Executive Committee was unanimously approved.

The Secretary reported the recommendation by the Executive Committee of Dr. Henry E. Darrah for membership in the Association. On the motion of Dr. William M. Muncy the election of Dr. Darrah was made unanimous.

The President announced the receipt of the obituary tribute to the late Dr. Charles N. Raymond which had been prepared by Dr. Herbert Armington and Dr. Edmund D. Chesebro.

The President announced that reports of Committees would be published in the next issue of *Medical News*, and he then called for adjournment, at 11:20 p. m., with a rising vote of appreciation for the services rendered by Dr. Utter as President of the Association during 1942.

RECENT BOOKS

THE MIND AND ITS DISORDERS. By James N. Brawner, M.D. Medical Supt., Brawner's Sanitarium, Smyrna, Ga. Cloth. Price $3.50. Pp. 228. Atlanta, Ga. Walter W. Brown Publishing Co. 1942.

This book is an excellent practical handbook of Psychiatry with a modicum of neurology added to make a complete picture. It is written simply, with a minimum of psychiatric clichés which are so irritating to the ordinary medical man. It covers very well a wide field and could be included in the general practitioners' library with profit.

It is not a reference book and in no sense of the word is it meant to be an authority on any one psychiatric picture. It is not an encyclopaedia nor was it written to be.

Dr. Brawner deserves praise for having gotten together an admirable, simply written, general summary of the field of psychiatry. I heartily recommend it to the attention of the average medical man whose knowledge of psychiatry is usually lamentably small.

GEORGE L. YOUNG, M.D.

THE HAND, by Condict W. Cutler, M.D., W. B. Saunders Co.

This is a comprehensive, excellent monograph on probably the most important subject in the realm of surgery. The one thing which gives man his great advantage over the so called lower animals is the elaborate versatile piece of mechanism at the distal end of his upper extremity. His much vaunted intellect would be of little service to him could he fashion none of the tools which build his civilization or even grasp a club to make him more physically equal to the powerful brutes.

And yet in our hospitals hand surgery is frequently left to the interns, while the august visiting men devote their skill to saving for a little longer suffering a pindling percentage of stomach cancers or to obviating a limp which a poorly handled lower leg fracture might give its owner.

A short section at the beginning is devoted to summarizing the high spots of the intricate anatomy without a detailed knowledge of which accurate surgery cannot be done.

The next 80 pages deal with acute infections, the remarkably specialized treatment of which Kanavel put on a firm basis over a quarter century ago. We have seen many otherwise competent surgeons who we felt had not deigned to master this detail.

After this are 75 pages on Specific and Chronic Infections with a bibliography of 42 articles. Some of this looks like padding. It is not demonstrated that there is great peculiarity in the hand as regards gas gangrene, tetanus, anthrax, glanders, rabies or lupus for instance.

The following few chapters on burns, contusions, wounds, etc., have some excellent points especially a fairly elaborate discussion of the surgery of tendons.

Fractures, not an elaborate subject when the hand only is considered immediately become of great interest in the carpus and forearm. The Jews speak of the "fuss" when they get below the groin. Dr. Cutler commits a Hebraism when he brings the hand so high. But his chapter on amputations and compound fractures is a good one.

The remarkable modern work on repair and construction by Koch, Iselin, Bunnell and others is touched on lightly but yet in a suggestive and admirable manner as is the related subject of deformities.

"Tumors" presents little particularly characteristic of the hand but the final chapter on Constitutional Diseases shows interestingly how these manifest themselves in the hand.

Despite some minor matters open to small criticisms we consider this a good book and general surgeons who expect to work on the hand should have access to it.

MANUAL OF DERMATOLOGY by Donald M. Pillsbury, Marion B. Sulzberger and Clarence S. Livingood. A military medical manual — W. B. Saunders Co. 1942.

A valuable pocket manual by leading dermatologists, containing a large number of good illustrations of the most common dermatoses, many almost life size, and many outline charts useful in diagnosing a case by its distribution.

A good feature of the manual are the blocked short sentences, Stokes's style, helpful in attracting the attention of the reader to the most important points.

Sound therapeutic advices, with do's and don't's and a substantial formulary are included. Emergency is not overlooked, as, for instance, the suggestion of the use of fresh milk for a wet dressing.

F. RONCHESE, M.D.

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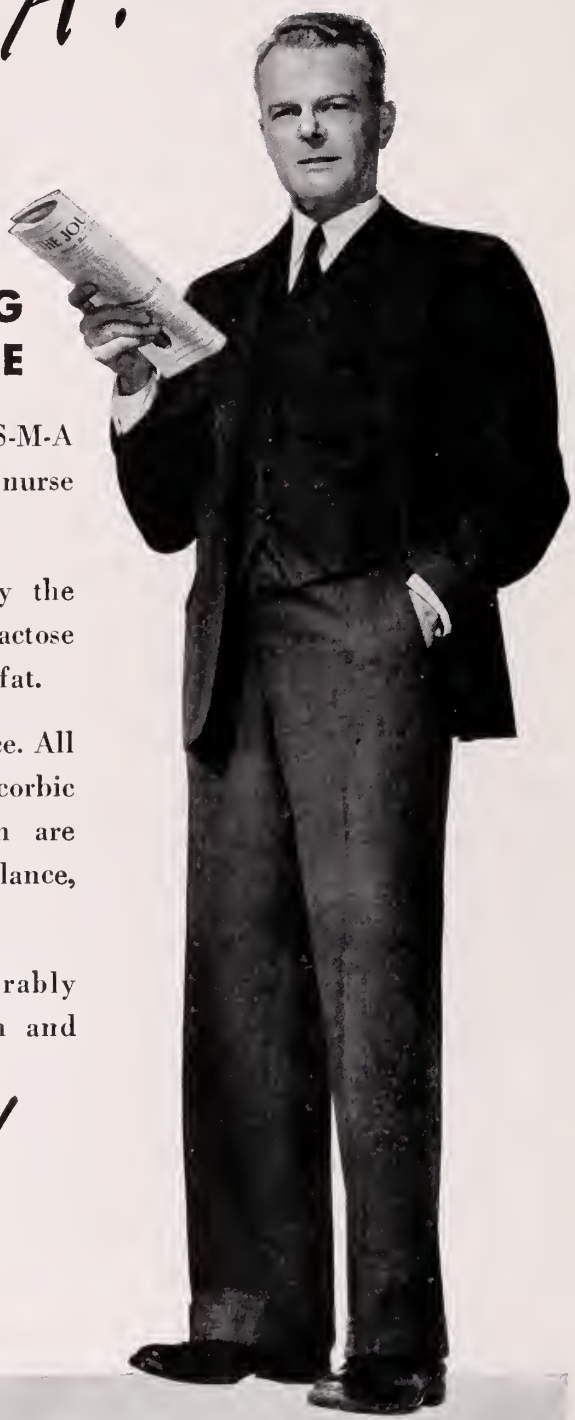
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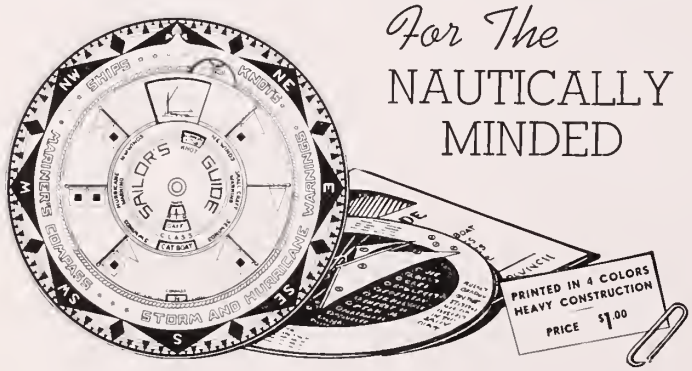
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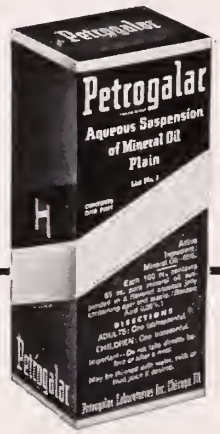
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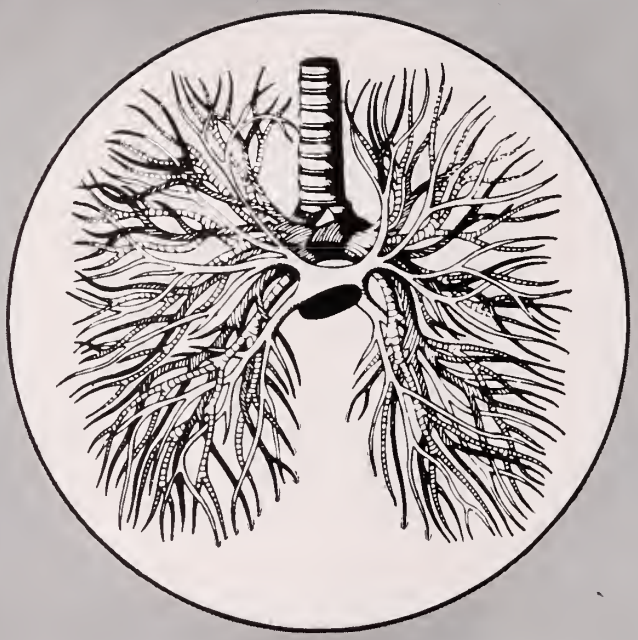
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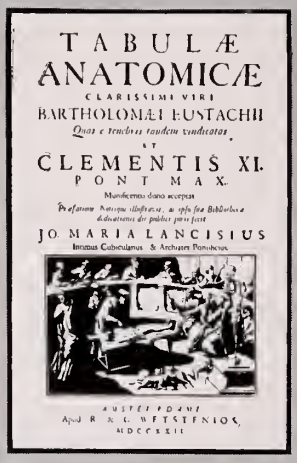
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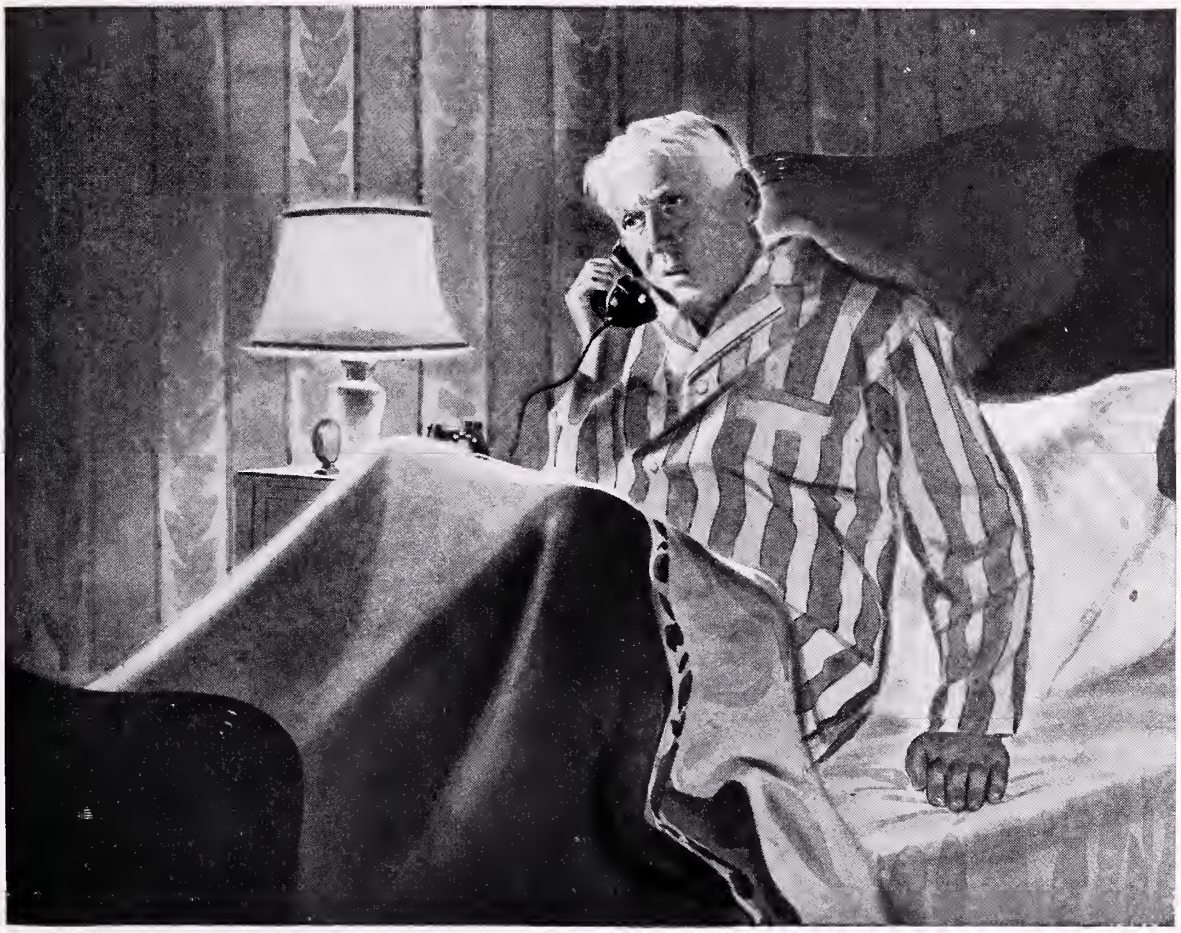
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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
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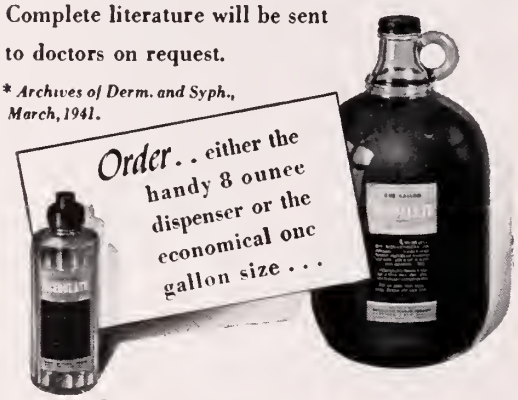
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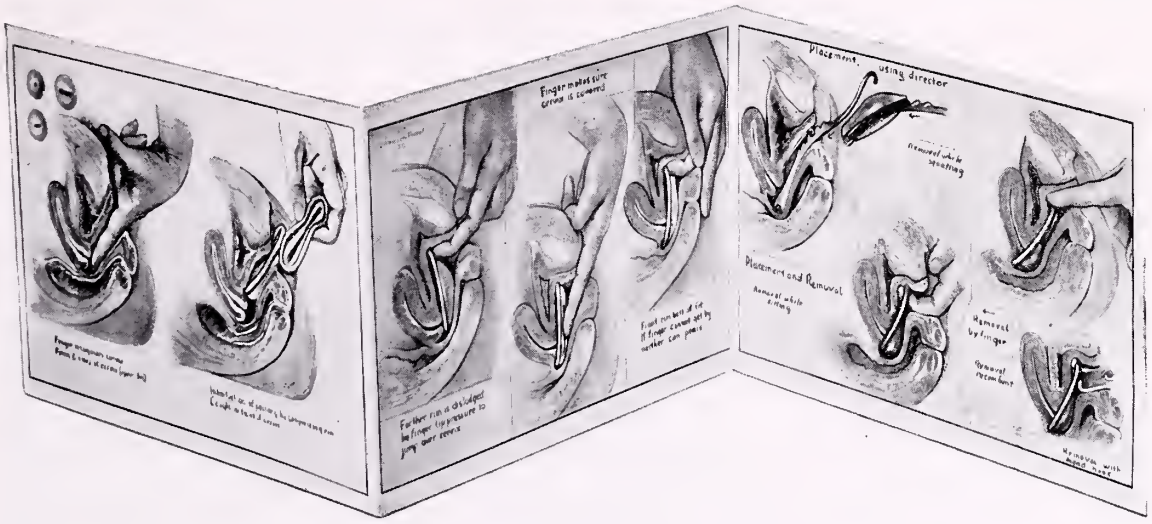
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THE RHODE ISLAND MEDICAL JOURNAL

Volume XXVI FEBRUARY, 1943 Number 2

PRESIDENT'S ADDRESS

Providence Medical Association

Dr. Henry E. Utter

The 96th year of the Providence Medical Society has passed into history. Nineteen hundred and forty-two has been a year when war has dominated the picture and one after another of our members has entered the armed forces until at the present moment 115 are serving their country at home or abroad in the common endeavor to subdue the enemy. We have all been much interested in their activities and travels of which our secretary has kept us informed. We on the home front have worked hard and when our men return, we trust that our own loyalty to them will be sufficient evidence to assure them as secure a place in our midst as that which they left when they joined the army or navy.

For the first time, this year we gave up the February meeting of our association to join with the Rhode Island Medical Society. This winter meeting will probably remain a regular feature. Also the June meeting was eliminated to permit co-operation with the state society. Members of this association during the year have been asked to meet with the Rhode Island Unemployment Compensation Board relative to the Cash Sickness Act; we have been asked to confer with state and city officials concerning the position of the Chapin Hospital in our community and we have been indeed gratified to know that this hospital with state aid is to remain under the administration of our city government. Our Society feels that in every respect in matters of state or city health, we have had the complete co-operation of Governor J. Howard McGrath and Mayor Dennis J. Roberts. We would like to express our thanks to them and we trust that our relations with our public officials will be as pleasant in the future as they have been in the past. Only by such co-operation may we hope to reach a satisfactory solution of our many medical problems which we certainly face in the near future.

Your Executive Secretary has been busy throughout the year; his radio talks on "Health in the News" covered many pertinent topics and he has received just recognition for his work from many sources. He attended the meeting in Chicago of the Secretaries and Editors of State Societies and brought home with him a report which was printed in the *Providence Sunday Journal*. He has given much time to Civilian Defense and Assignment and Procurement. Mr. Farrell has distributed complete information about gas rationing. He has further worked with O.P.A. authorities and the plan adopted by the Providence Medical Association was copied in many other parts of the country. Cigarettes were sent to our members of the armed forces overseas and a printed Christmas message was mailed to all our members in the American forces. I wish here to express to him my personal thanks for his many kindnesses to me and for the many burdens he has taken from my shoulders; this has been to me a year of pleasure which was possible only through his inexhaustible energy and efforts. We are indeed fortunate in having Mr. John E. Farrell as the real executive head of our association.

I wish to express my thanks to the committees who have worked so tirelessly throughout the year. The Entertainment Committee directed a golf tournament in the spring which was a grand success and throughout the year this committee has furnished us with excellent repasts after our monthly meetings. Our committee on Tuberculosis has discussed and met the advancing problem of tuberculosis which can be only on the increase in such

times as these through which we are passing. The members of the Executive Commitee have been faithful in their attendance at our meetings and have aided materially in solving the many questions of the year. I would like further to express my thanks to all the officers of the association and members of other committees. To Miss Dillon and her corps of District Nurses, we must also give recognition for their willingness to help in all matters relative to the work of our Association.

Particularly do I wish to thank the members of the Association who have given of their time and knowledge to contribute to our scientific programs. One joint meeting was held with the Children's Heart Association of Rhode Island and I think in the future we should follow the plan with other organizations interested in branches of medicine.

What lies ahead? Where does our medical profession fit into the picture? For the Providence Medical Association and for all county societies there remains and must be continued in perpetuity the function of keeping the local members of the society informed upon the advances in medicine; we must continue our medical meetings from year to year that our men may participate in the spreading of knowledge which is of benefit to mankind. Research workers the world over will continue their studies and new discoveries in the diagnosis and treatment of disease will be made. No form of government can stifle, regardless how hard it tries, the investigative initiative of individual workers; no social order, regardless of its strength, can keep us from learning of the findings of these men, and may we hope that no form of government or social order will make any attempt to eliminate the researches of medical men. Medicine is too finely ingrained into the very nature of men who accept this profession as their life work It is strong drink to them. Our duty must be to present matters of interest in medicine, to sift out the good from the chaff and offer the same to the members of our society for their mental uplift.

The Rhode Island Medical Society must continue to strengthen its position as one of affluence in the medical problems of our state. We must recognize it as the parent organization, and it must guide the medical profession in this state. Each county society should be a subsidiary of the state association and every medical man in the state should be a member of the Rhode Island Medical Society.

It is hoped that in the not too distant future some arrangement may be made whereby each physician may pay a single annual fee for membership in both the state and county societies. Our state organization should study each piece of legislation involving the practice of medicine and each member must accept his share of responsibility in offering aid in whatever health venture our state may decide to embark. No longer may we sit in our comfortable chairs of complacency and allow the law makers to guide our medical careers. The world about us is changing too rapidly and we must take our part in shaping its affairs lest we be lost in the midst of chaos from which we can extricate ourselves only with the greatest difficulty.

It is more than possible that we must actually run for offices in the state legislature and if not this then we must have a paid representative in the legislature who will keep a watchful eye upon all medical legislation, and he in turn must keep us informed upon these matters. This is not playing politics but merely sound good sense. Our own executive secretary has in the past kept his watchful eye upon such matters, and repeatedly informed the Providence Medical Association about these affairs. He is too busy at present for us to expect him to do this work, but even though we appoint some member of the legislature to do this for us, we all know that little will escape our secretary. Our state society must study every angle of the national and state social security program. The Rhode Island Medical Society is forging rapidly ahead and each member of our local association must pledge himself whole-heartedly to the furtherance of the policies of the parent organization. We can still remain the strong institution which we are, but we must share our fortune with the mother society. Our strength will be hers.

Socialized Medicine

In the world at large there is a social revolution shaping itself as the aftermath of the World War. We have in Germany, National Socialism; in Russia, Commmunism; in Italy, Fascism and in our own United States, the New Deal. Whatever their differences they have one thing in common, namely government control of the whole nation and to

some extent the resultant thwarting of the individual. Such a state of society cannot long persist. When any government loses sight of the fact that its strength lies only in the influence and effort of each individual as a component part of that nation, that government has lost favor even before its plan is formulated. History teaches us that no nation, great or small, in the past has been able to make its individual members subservient to the faction in power. Man was born to be free and any interference with his freedom can only bring dissension and strife. Dictatorships must all eventually fail and the citizens of any country who bestow upon any one man too much power sow the seeds of their own future unhappiness. And yet the man who wields the sceptre will continue to add to his power as long as his fellow citizens allow the process to continue. God in His infinite wisdom has so far given to no one man the personal power to dominate any one nation or the world. National unity is dependent upon the character of each citizen.

Social Security in anticipation of the future is a topic for discussion in one form or another in almost every nation on earth. Each country will have its own separate problems, but all plans do and in their ramifications will have certain common provisions. Medical care becomes involved in the process because social security is closely linked with the health of the nation.

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2. Cash Sickness Benefits
3. Unemployment Insurance

Plans are operative which involve one or two of the above regulations, but according to Sir William Beveridge only three countries, Poland, Bulgaria and New Zealand have so far made provision for all three risks. Several of our own states provide Old Age Pensions, most have laws relative to Unemployment Insurance and Rhode Island, as the first state in the Union, has passed a Cash Sickness Act, which becomes operative on April 1, 1943. The experiment in Rhode Island will be watched throughout the nation and other states will probably follow, with the possibility of a National Cash Sickness Act in the none too distant future. Labor is certain to dominate our politics in the years to come and their demands for Social Security will doubtless be given first consideration. Should the triad mentioned be sufficient to insure the major part of our population against want in old age, sickness and unemployment dependent upon waves of national economic periods of depression and prosperity, it is possible that regimentation of our medical profession will stop beyond the point at which our services are required in the administration of the acts.

Social Security laws will make available many paid medical positions. These offices should be filled by qualified medical men for only by honesty and efficiency can the operation of any plan be successful. It is imperative that these men be appointed by Civil Service Examination. Political favoritism should have no place in filling these positions. These examinations should be conducted by the United States Public Health Service. A national board of examiners would have no reason to play politics, but no local unbiased board of examiners could possibly be found to conduct such examinations.

Even though the wants of the laboring class of people are cared for by National Health Insurance, there still remains a large number of the population who derive their income from other sources and private practice will continue in this group of citizens. Whatever plan is evolved to render medical care to those benefited by health insurance there will still be many of this class who will choose their own physician. The place of the private doctor will still be secure.

If, however, the plan of social insurance affects each citizen, and we all contribute, then complete regimentation of our profession will result. Our duties will be delegated to us by a central control agency, our patients will no longer have their choice of a physician and specialists will be allocated to the cases needing such service. Nation wide social insurance will permit of no other method unless as in the past, although we pay taxes for public education we may send our children to private or sectarian schools; we may pay taxes for old age benefits but this does not prevent us from purchasing an annuity from an insurance company for the same purpose, nor should the whole of our income be confiscated by the government in taxes; we still have recourse to a bank savings fund. Like-

wise, although we contribute to compulsory health insurance, it is indeed doubtful if our citizens will be denied the privilege of calling upon the physician of their own choice. Even if this were not permitted, it is doubtful if any of us would obey the law to the extent of not attending upon a friend who requested our medical assistance. If we do not heed the call, we no longer live in the land of the free and the home of the brave.

In our armed forces we are trying the experiment of impersonality in medicine. When a member of the medical staff in the Army or Navy is off duty, he is relieved of all responsibility in the care of a medical case. It will be interesting to note the reaction of these men upon their return. Their opinions should help in shaping the course of socialized medicine. The impersonality of socialized medicine may work in the Army, but when our wives and children are involved, I wonder how we as physicians will take to the idea of accepting in our homes the physician who happens to be on duty when perhaps we know all too well his personal qualifications for good or bad. It is doubtful if medicine in this country will ever be completely socialized. We are a race of immigrants perhaps several generations removed, but those who landed on the shores of Virginia and Massachusetts came here with a spirit of adventure in the quest of freedom, and those who came later were a restless group inspired with ambition to secure greater things offered by this country. This vital essence of independence exists in the soul of every American and it is questionable if this fire can be completely extinguished.

Whatever the future brings us we must study the trend and be prepared to join in whatever is right for the benefit of mankind. If socialized medicine is to be the cure for our ills, we must help the plan and give freely of our advice in matters pertaining to health. We have seen too many reforms which theoretically seemed perfect and yet which failed under operation. During the recent depression, we have seen our tax money used to employ men upon projects artificially created for their benefit. Little have these men appreciated what was done for them and little have they given in return. Their apparent desire has been to give not of their best but as little as possible. So with socialized medicine, there will be much unhappiness before a satisfactory plan becomes operative. If universal national insurance is adopted, there will be a change in the type of man entering the profession of medicine. Members of our cult have for generations affiliated ourselves with medicine because we liked the independence, the opportunity to express our own ideas and practice the art according to our desires. Medicine is not a perfect science and any scheme which aims toward the regimentation of our profession will find itself confronted with the obstacle of overcoming what has always been a manifestation of the personal element of an individual asserting itself. Personality can never be regimented. Personality is made of a too intangible fibre.

Meantime we must not lose faith in ourselves. The individual will eventually reign supreme regardless of all social experiments. We must not forfeit our own individualities nor our power of insurgency. Truth and righteousness will prevail. In the words of the sage who has few peers, "To thine own self be true and it must follow as the night the day, thou canst not then be false to any man."

PROGRESS NOTES OF THE 48TH EVACUATION HOSPITAL

(The Rhode Island Hospital Unit)

Capt. W. Lessel Leet, *Historian*

The Staff of the Rhode Island Hospital was asked to create a tentative organization of officer and nurse personnel for an evacuation hospital unit of the army many months ago, but action did not begin to crystalize until the Pearl Harbor episode. After that, through the weeks and months, a hundred or so doctors and nurses had completed the then very slow process of qualifying for and receiving commissions in the Army of the United States. Included was a quartet of administrative officers from the staff of the Rhode Island Hospital Trust Company.

There was a brilliant party and send-off at the Agawam Hunt Club and the officers of the 48th Evacuation Hospital began active service on August 17, 1942 at Fort Devens, where two hundred enlisted men, already in a fair state of organization and training, awaited us. The nurses were to come later.

Devens Days

Officer training began at once. With the aid of several who had had longer service and previous experience, we began lifting ourselves by our boot straps. Training and toughening were the orders, so close order drill, hikes, marches with pack, calisthenics, and professional lectures filled our days. At odd times we secured equipment from the post exchange and from the quartermaster. A short two weeks of this and we were off for maneuvers. Before continuing, it may be well to explain and describe an evacuation hospital.

Evacuation Hospital

Ours is the larger type, a 750 bed affair, capable of expanding to a thousand bed capacity if need be. It is commanded by a colonel and staffed by fifty medical and administrative officers, fifty nurses and four hundred or so enlisted men of all grades. We can render nearly every service you could expect of a 750 bed hospital including medical, surgical, x-ray and laboratory. The hospital may be housed entirely in tents, but if possible it uses available buildings in part. The location should be out of enemy artillery range at least, and is as mobile as the situation requires, being able to pack up or set up in a half day if necessary.

Doctors' Dilemma

The training and organization of such a hospital is no slight task and it was with some concern that we faced our problems. Several factors favored our successful development. We were at war and business came before pleasure. The professional calibre of our officers and nurses was very high. Also, there had been considerable care exercised in their selection and, as a result, we had people of high character. Knowing each other as we did, knowing each other's abilities and attainments, was another advantage which gave us confidence. All of which made for good hospital organization. Harmony was a natural sequel and friction was at a minimum.

Likely Leaders

Lt. Col. William A. Mahoney assumed initial command of the organization and guided it through the early days of hospital organization in Tennessee. Lt. Col. C. L. Leedham, a regular army medical officer, took over at this point. His broad experience and positive direction did much to foster our progress. Through leadership, tact, and patience he soon won the respect and esteem of all. It was with great satisfaction, late in December, that we saw his silver oak leaves replaced by the silver eagle of a full colonel.

Murfreesboro Memories

The 48th Evacuation Hospital, after only two weeks of active duty, was ordered to the field to take part in the Fall 2nd Army Maneuvers in Tennessee. We were to serve as a base field hospital. The medical set up, in simple language, was as follows. The sick and injured from the 50,000 or so troops taking part in these armored force maneuvers were treated on the spot, or if not promptly correctable, were sent to the rear to be treated by a medical battalion if not more than a five day affair, or sent on by ambulance to the evacuation hospital. The latter expected to return a man to duty within fifteen days or evacuate him to a station hospital farther in the rear. In this manner 2,233 patients passed through our hands during ten weeks.

Maneuvers may be sham battles for the combat troops, but for the medical forces they are the real thing. Mechanized forces, night problems, river crossings and the like all exact their toll. We received injuries in all degrees of severity together with sickness to be expected among 50,000 men in the field.

Nurses Notes

Our fifty nurses, already tried and true in civilian life, were eagerly awaiting their own activation which sent them to Fort Devens in September, while we were at the Tennessee maneuvers. They joined us in the field a little later, in time to receive patients with us.

The army has great respect for its medical service and this most certainly includes the nurses, who bear relative rank and, recently, equal pay with other officers of the army. All wear the gold bar of second lieutenant with the exception of the chief nurse, Miss Matilda Dykstra, who, as first lieutenant, wears bars of silver. They hike, drill and march with the best of us and, most of all, they try to be patient with those who call them "Waves" and "Waacs" because they are justly proud of being "Army nurses".



48th EVACUATION HOSPITAL

Reading left to right, first row: Major Frank B. Cutts, Major J. Merrill Gibson, Major Arthur E. Martin, Major Eric Stone, Lieut. Col. William A. Mahoney, Commanding Officer Col. Charles L. Leedham, Lieut. Col. Herman A. Lawson, Major A. J. Meister, Major Edward G. Melvin, Major J. Murray Beardsley, Capt. Sullivan.

Second row: Capt. I. E. Garber, Capt. Steiner, ..., Capt. Edward R. Squier, Capt. Robert G. Murphy, Capt. W. Lessel Leet, Capt. Walter S. Jones, Capt. Frederick A. Webster, Capt. Samuel D. Clark, Capt. Francis Hollard, Capt. Irving Beck, Capt John S. Dziob.

Third row: Lieut. Hubert Holdsworth, Lieut. William J. H. Fischer, Capt. Vincent Zecchino, Capt. Henry G. Lutz, Capt. Edward Damarjian, Capt. George F. Conde, Capt. Grenniger, Capt. William W. Teahan, ..., Lieut. D. Richard Baronian, ..., Capt. Allen C. Hall.

Fourth row: Lieut. Milton Korb, Lieut. Keith H. Gaudey, Lieut. George A. King, ..., Lieut. Palmer Congdon, Lieut. William W. White, Lieut. Thomas Perry, Lieut. Wilbur B. Manter, Lieut. John A. Dillon, Lieut. Sirois, ... Lieut. Chauvais, ...

Copies of this photograph may be secured from the Fort Devens Studio, 4 W. Main St., Ayer, Mass. The price of the picture is $1.00, including packing and mailing.

Their duties are similar to those already learned, except that the army nurse, is, first of all, a supervisor of the enlisted war attendants and, secondly, she must strive to maintain her professional standards with greatly limited equipment. She is assisted, often times, by surprisingly proficient ward attendants and by convalescent patients who are required to serve the ward needs to the best of their ability. A successful nurse must secure the cooperation of enlisted and patient personnel.

Medical, surgical, and isolation wards are maintained and, of course, there are complete surgical teams and operating rooms. In the field, the latrines and mess halls are apart from the wards, the cots are low, and if the patients are able, they go to their meals.

Women's Wear

Any discussion of army nurses should include their clothes. In the fixed hospitals, they wear the conventional white with cap, but in the field, our girls wore dark blue slacks with light or dark blue shirts and no caps. It was something to see them flit about among the low canvas cots as they efficiently performed their duties. For the street, there is the dark blue coat and light blue skirt, the traditional two tone of the army, together with a pert overseas cap at just the right angle, and a navy blue overcoat with a detachable lining. A dark blue fatigue dress is as becoming as it is popular, as is also a beige summer uniform in which all the nurses shine! There is a subdued, dark red trimming on most of these garments together with the proper gold ornaments of rank and service. Hats and caps to match defy my descriptive powers, but they are all very attractive.

Train Transportation

It is worth while to hear of present day methods of troop movement. Not the least of the railroads' job is to transport millions of men about the country. Pullman sleeping cars are used as far as possible, two men to a lower and one to an upper, with day coaches used when necessary for non-preferred troop transfers.

A trip is well organized with a train and car commanders, soldier communications with the outside world are suspended, and previously assigned accommodations are speedily occupied by the troops under full field equipment. During the trip, the men read, play cards, sing, sleep, converse, while their train, stopping rarely except for changing engines and for service, speeds to its secret destination.

Baggage cars are rigged as mess cars, field ranges are set up in great sand boxes and "chow" of the regular high quality comes three times a day. The troops arrive in good condition.

Freight is placed in freight cars and vehicles are mounted on flat cars. Thus we steamed out of Murfreesboro with the entire personnel and equipment of a 750 bed hospital in some twenty-five cars; two cars of officers, two of nurses, and several of enlisted men, freight cars, vehicle laden flat cars, and, of course a caboose.

Situation Successful

We felt pretty good when we packed up to leave Tennessee for our home station at Fort Devens. We were seasoned troops in the sense that we had successfully performed our mission in the field. Perhaps successfully is too modest because as soldiers we were getting by, but professionally we seemed to be regarded as tops. There was much evidence to support it and a great deal of praise came our way.

Food Facts

Food has been variable. For the most part, we have lived on the regular army rations which cost only sixty cents a day. As this is for the unprepared food as the army buys it, we get a lot more for our money than you would expect. Modern nutrition influences this army and dietitians play a part. We get lots of fresh fruit and many of the green leafy vegetables. The three meals are substantial and suited for workers.

In the field our kitchen must feed, not only a hospital personnel of 500, but all of the patients and, of course, there are meals for the night shift, too. Unlike the old army, beans are infrequent and there has been ample meat, coffee, and butter. Materials are excellent and the preparation varies with the skill and experience of the kitchen personnel. Thus far, too, post exchanges have always been near at hand with soft drinks, ice cream, etc., at very reasonable prices.

Troop Trains

Fort Devens is a reception center for selectees. The recruits remain the few days necessary to get outfits and are then forwarded on special trains, several hundred at a time, to another camp for basic training. Medical officers of the 48th were sent along on these trips from time to time as train surgeons. The latter and the train commander would be the only commissioned persons on the train. Several non-coms. including a mess sergeant would comprise the only experienced soldiers, the several hundred others being raw recruits. Generally speaking, soldiers were delivered safely and well to all parts of the United States while our officers enjoyed and profited by the experience. Many nurses too had the opportunity to accompany the wounded from foreign service in a hospital train.

Rippling Rumors

Rumors play a large and unimportant part in our lives. Chiefly, they deal with our time of departure and our destination from wherever we are, that is, to Fort Devens, to maneuvers, from maneuvers, etc., etc. An October issue of mosquito nets satisfied many that we were destined for the tropics, probably North Africa. The next day we were given overshoes, a desire of the supply department to clear a space seemed to be the correct explanation. All parts of the Atlantic, Pacific, Indian and Arctic oceans have received serious rumor consideration. Only the Antartic has been neglected. Apparently a change in the War Department's plans kept us from the North Africa affair last October, but we didn't hear of this possibility, even by rumor, until long afterward.

Service Shots

Each of us now has been vaccinated or inoculated for smallpox, tetanus, typhoid and paratyphoid A & B, cholera, and typhus. Local soreness is common, occasionally there are reactions, rarely severe and generally, except for the smallpox, over in a day or two. As a medical outfit, we inoculate ourselves, and others as the demands arise.

Army Amenities

Our beds have not always had springs, we have lived under many restrictions, calisthenics were compulsory, sanitary facilities sometimes at a distance, but there was much to console us. Most of the increasing burdens of the civilian were not for us. We ate very well, considering, with evidently more meat, eggs, and butter than the civilians. There was time for pleasure, too. Doctors and nurses had weekly dances in Tennessee and weekends in Nashville were not rare. In the West, we got to Riverside and Hollywood. We have lived in the deep South and the far West; we saw the cotton fields and southern negroes, the Rocky Mountains and the plains and deserts. We got around a lot! We have been fortunate too in that our program has moved along briskly with hardly a dull moment. Our morale is high and our outfit has been envied by many.

Devens Departure

After a fine day trip on the train via Atlanta, Georgia, we were back at our home station, Fort Devens, for further training. Hospital assignments at Lovell General and New Station filled our mornings, while drills, hikes, marches, gas drills and lectures for officers and nurses occupied our afternoons. Some went to Rhode Island Hospital, Massachusetts General, Boston City, and Walter Reed for special work while others were at service schools at Carlisle and elsewhere.

Suddenly, at the end of December, all these were summoned back, leaves were cancelled, passes were brief. The 48th was "On Alert", supposedly for foreign duty. On January 6, 1943, we boarded the train for our secret destination.

En Route via West Coast
January 17, 1943

POSTERIOR ROOT SECTION FOR ATHETOSIS

Thirty-two Year Report

Lucius C. Kingman

Case of R. H.

Seen professionally in July 1909. Had been known to me for twenty years.

Had a so-called birth injury. The left arm was never normal in size or function. As a small boy he had some spasmodic movement of this arm so that his fingers would scratch his chest and he acquired the nickname of "foolish". From about 1885

to 1906 had no spasmodic movements. He graduated from Manual Training High School in 1898. After that he was employed in various semi-skilled mechanical jobs. He could use tools but had to place the tool in the left hand with his right when it then could be grasped. He could not pick it up with his left. His speed of work was from 1/3 to 1/10 normal.

In 1906 he again began to have spasmodic flexions and rotations of the left upper extremity. This increased during the next three years so that he could not work, was unwilling to go out before dark because the boys followed him and he finally spent his days in bed lying on the arm to keep it quiet. He then came under the care of the late Dr. William MacDonald who, following the suggestion of Dr. Spiller, advised posterior root section.

This I did in July 1909. The left posterior roots of the 4, 5, 6, 7, and 8 cervical and 1st dorsal were cut. Following operation there was some spasm of left arm and left pectorals for a few days. At the end of a month there was no spasm but some associated movements when right arm was moved. He could grasp objects but only by sight, was helpful about the house and going out of doors. At the end of three months he began a clerical job. In 1911 he moved from Providence and out of my observation to take a position as time-keeper in a mill which job he held until 1926 when discharged on the bankruptcy of the company. No regular employment since though not on account of arm disability.

He was married in 1922. In 1926 he received a compound fracture of the left forearm. This was painless. There was solid union but with an angular deformity. He developed a large scrotal hernia which was a factor in keeping him from employment.

While on a visit to Providence was examined by me on June 17, 1941.

Male—63—

He is mentally alert and well adjusted to his disability. He can dress himself. The whole left upper extremity sweats easily and at times has sensation of cold. Occasionally the forearm moves unconsciously to right angle flexion. If nervous or in a hurry he may get slight twisting contracture with crossing of the fingers. He knows vaguely the position of the arm with his eyes closed; by sight can put hand within few inches of designated spot; can oppose thumb and first three fingers and grasp objects but by sight only. There is complete asterognosis of the left upper extremity. There is slight scuffing of left foot. The left humerus is 1½" shorter than the right. The left lower extremity is 1" shorter than right. Reflexes are absent in left upper extremity, normal elsewhere. Superficial tactile sense, perception of heat and cold and tuning fork sensation are absent in left upper extremity. Deep sensation present but diminshed. He is pleased with the result.

COMBINED MEETING OF MEDICAL SOCIETIES

The Providence Medical Association and the Rhode Island Medical Society held a combined meeting at the Medical Library on the evening of Feb. 4. Dr. Emery M. Porter, President of the Association, opened a short business meeting and on the recommendation of the Executive Committee the following motions were passed.

1. "That the Association recommend that the Providence Health Department employ an additional full-time sanitary inspector to accelerate the inspection and the improvement of sanitary conditions of all eating and drinking establishments in the city of Providence."

2. "That the Executive Secretary prepare a suitable postcard to be mailed to each member for return to the executive office upon which the member might indicate his willingness, or not, to answer emergency calls directed to the telephone company, the police department, and similar agencies."

Dr. Porter then turned the meeting over to Dr. Chas. F. Gormly, President of the State Society, who felicitously observed that one had to be a president to qualify for an appearance on this program and the following program was presented.

Dr. Herman C. Pitts, President of the American Society for the Control of Cancer, spoke on "The Rhode Island Cash Sickness Act".

Dr. James C. McCann, President of the Massachusetts Medical Service, spoke on "Prepaid Medical Care and the National Outlook".

Dr. James E. Paullin, President-elect of the American Medical Association and President of the American College of Physicians, spoke on "The Contribution of the Physician in the Present Crisis".

The new Constitution and By-Laws as presented to the House of Delegates was adopted by the meeting.



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AUGUSTINE W. EDDY, M.D.

THIS IS OUR PRESIDENT

It would never do to have an electrotype of Dr. Charles F. Gormly unavailable for immediate use in the MEDICAL JOURNAL. Activities at Tufts, in the Medical Societies or among the Dental men have kept it pretty frequently in use.

He is the ideal presiding officer as all will agree who have watched him do this at medical meetings or at the fine Medical Grand Rounds on Saturday mornings at the Rhode Island Hospital. His Gay lecture at Tufts last year was a delightfully straightforward and inspiring address.

And so his friends and associates in the Rhode Island Medical Society feel happy over the testimonial dinner with the presentation of award and scroll that Dr. Gormly has received from the Rhode Island State Dental Society.

Congratulations to the Dental Society for their well considered action.



CHARLES F. GORMLY, M.D.

DATE AND PLACE OF BIRTH: February 2, 1886, Providence, Rhode Island.

GRADUATE OF: English High School, Providence, Rhode Island.
Tufts Medical School, Boston, Mass., 1909.

POST-GRADUATE WORK: London, England and Vienna, Austria.

INTERNSHIP: Boston City Hospital, 1907-10.

HOSPITAL STAFF: Rhode Island, Butler, Miriam, Providence Lying-In and Charles V. Chapin Hospitals.

MILITARY RECORD: English Army, 1916-17; American Army, 1917-19 AEF.
Medical Reserve Lieut.-Colonel.

SOCIETY MEMBERSHIPS: Rhode Island Medical Society, Providence Medical Association, American Medical Association, New England Heart Association and the American College of Physicians.

PAST PRESIDENT OF: Providence Medical Association, 1934-35.

PRESIDENT OF: Rhode Island Medical Society.

PHYSICIAN-IN-CHIEF: Rhode Island Hospital.

AUTHOR OF: "*The Measure of a Physician's Greatness*," a George W. Gay Lecture on Medical Ethics, presented at Tufts College Medical School, March 13, 1941.

TESTIMONIAL DINNER

tendered by the

RHODE ISLAND DENTAL SOCIETY

to

CHARLES FRANCIS GORMLY, M.D.

Doctor of Medicine, President of the Rhode Island Medical Society, Fellow of the American College of Physicians

GREETINGS:

The Rhode Island State Dental Society grants to you this day the medal of award and citation of the Society.

The grant was decided because of your devotion to obligation and duty; because of your dynamic energies that allowed nothing to interfere with your desire to always serve those who asked your services.

We have noted that it made little difference to you whether the call came from the private patient or whether it came from the ward in a hospital.

The Rhode Island State Dental Society has recognized your leadership, your ability in education and your fostering spirit that gave many interns courage to venture forth into the practice of medicine.

Beyond this also your fatherly care has watched over them, ever willing to lift them up and spur them on. When necessary you knew when to be sympathetic and when to be severe.

We honor you because you have been ever ready to fight to preserve the principles of the Profession you love so much: Medicine.

We honor you, Doctor Gormly, because you have honored Dentistry. You have helped us by your wisdom freely given. We greatly appreciate your accomplishments in the field of medico-dental and legal associations. We honor you because of your friendship.

THE RHODE ISLAND STATE DENTAL SOCIETY

Thomas W. Clune, D.M.D., *President*
Charles F. McKivergan, D.M.D., *Secretary*

January 27, 1943

RHODE ISLAND MEDICAL SOCIETY

House of Delegates—January 21, 1943

The secretary read the report of the Public Health Committee, Doctor Pitts, Chairman, and it was accepted and placed on file.

The report of the Committee on Commercial Exhibits at the Annual Meeting, Doctor Bradley, Chairman, was read by the secretary and accepted and placed on file. It was voted that the By-Laws requiring a two-day meeting be suspended and that the length and time of the meeting be left to the judgment of the Officers.

It was voted not to send delegates to other State Society meetings this year.

By vote of the meeting, Doctor Brackett was nominated as the Rhode Island Medical Society member of the Board of Directors of the Hospital Service Corporation.

Doctor Hammond, the Chairman, presented the report of the Committee on Constitutional Revision. It was voted that the Rules and By-Laws as recommended by this committee be accepted by the House of Delegates and recommended to the General Session for adoption. A rising vote of thanks was given to Doctor Hammond and his committee for completing a very arduous piece of work.

Doctor Burgess, the Chairman, presented the report of the Committee on an Executive Secretary. It was voted that the recommendations of this committee be adopted, including the employment of an Executive Secretary. It was voted that the following recommendation of the Council be adopted: "That the Council recommend to the House of Delegates that a War Tax of $15.00, payable July 1, 1943, be assessed on the active membership not in the armed forces."

REPORT OF THE COMMITTEE ON PROBLEMS ARISING OUT OF ANY SHORTAGE OF PHYSICIANS IN RHODE ISLAND

Several meetings of the committee have been held, also the committee has been represented in joint meetings with the Rhode Island Procurement and Assignment Committee and at meetings of the Council of the Rhode Island Medical Society.

A report of the committee was read at the meeting of the House of Delegates held September 17,

1942. This report was printed in the November number of the R. I. Medical Journal.

Since that time the committee has kept informed on conditions in Rhode Island; also one of the members of the committee, by request, gave a radio talk over station WPRO on December 20, 1942, with the thought in mind of keeping the public informed relative to doctors and the home front. In this radio talk various suggestions were made in the interest of co-operation between the civilian population and the doctors remaining in active practice here.

It is felt by the committee that no acute shortage of doctors now exists in Rhode Island, and that there is now no serious medical emergency here in Rhode Island.

Respectfully submitted,

Elihu S. Wing, *Chairman*

REPORT OF THE COMMITTEE ON CONSTITUTIONAL REVISION

To the House of Delegates of the Rhode Island Medical Society:

The Committee appointed to revise the Rules and By-Laws of the Rhode Island Medical Society has completed its task, and submits herewith a revision of the instrument which is the supreme law of the Society. The assignment has involved a long and painstaking study of the present Rules and By-Laws together with an examination of the constitutions of most of the other state Medical Societies. We also wish to acknowledge the efficient assistance given by the Bureau of Legal Medicine and Legislation of the American Medical Association in submitting a tentative draft of these Rules and By-Laws, and in advancing sound arguments in support of many of the changes which have been incorporated into this document.

In the draft as submitted, the Rules and By-Laws have been enlarged and are displayed in an orderly arrangement with a table of contents and each Article and Section properly entitled to present the subject matter contained therein. The charter has been corrected so that it is an accurate reproduction of the original document on file in the State House in Providence. These Rules and By-Laws conform to the standards required by the American Medical Association without sacrificing the essence of the old text; nor do they surrender the independence, nor impair the traditions of this ancient and honorable society.

The Committee wishes to call your attention to certain specific changes in this draft of the Rules and By-Laws:

Article III—Membership. Members of component district societies may become Fellows of the Rhode Island Medical Society (1) by paying annual dues directly to the Treasurer of the Society; or (2) the Treasurer of the component district society may forward the dues of members to the Treasurer of the Rhode Island Medical Society. In this way each member of a component district society may become a Fellow of the Rhode Island Medical Society, or, as we hope, each component district society will vote to adopt the second form of procedure, so that all members of component district societies will automatically become Fellows of the Rhode Island Medical Society upon payment of the required annual dues.

Article V—Officers. The change in this Article is in line with the custom prevailing in many similar organizations. The First Vice-President is entitled President-Elect and the Second Vice-President is designated as the Vice-President. By this procedure the President-Elect is given one year to become initiated into the duties and responsibilities of the presiding officer and to formulate his policies for the ensuing year. The Vice-President will assist the President and officiate during the absence of the President.

Article VI—House of Delegates. The membership of this body has been changed so that members of the Council are not automatically members of the House of Delegates, except in the case of the five principal officers of the Society. By this procedure the House of Delegates, as the supreme legislative body of the Society, is composed of delegates elected by the component district societies.

Article VII—The Council. This body has been designed to act as the Executive Committee of the House of Delegates with a smaller membership than at present. Meetings are to be held six times a year. The Council may employ an Executive Secretary if so authorized by the House of Delegates. Such a policy would result in a healthy increase in the activities of the Society and provide useful service to the Fellows. If the suggestions proposed in Article III with respect to an increase in membership of the Society are adopted, it is highly probable that this desirable ambition may be realized.

Article X—Standing Committees. The alterations suggested in this Article conform with

changing conditions in the medical profession. The Committee on Legislation, State and National, has been designated as the Committee on Public Laws, and the Committee on Education, State and National, as the Committee on Medical Education. The Committee on Necrology has been dropped since its functions are more easily performed by the Secretary. The office of Curator has been eliminated since he has no duties. Two new Committees have been proposed, one on Medical Economics and one on Industrial Health.

Respectfully submitted,

HERMAN A. LAWSON (in absentia)
HARRY C. MESSINGER
WILLIAM P. BUFFUM, *Secretary*
ROLAND HAMMOND, *Chairman*

REPORT OF COMMITTEE ON EXECUTIVE SECRETARY

Introduction

1. The need for an Executive Secretary for the Rhode Island Medical Society is obvious to anyone who is at all familiar with the work that a state society does and should do. For many years it has been evident that the Secretary, always a practising physician from our own ranks, has been grossly overburdened with the routine work of his office. Merely to accomplish this routine has meant great personal sacrifice on the part of our secretaries in the past. Any failure to carry on the work of the Society along the progressive and helpful lines that would make our organization of maximum value to all the physicians of the state has been due, not to any lack of willingness or of progressive ideas on the part of our secretaries but to a lack of *time*.

In particular the need for extending the work of the organization throughout the state, and of keeping close touch with all the district societies could never be met. The presence of an able Executive Secretary, as well as taking up the burden of the routine, would extend the work immediately to all the physicians of Rhode Island and thus bring the full benefits of membership in the Society to all. In addition a secretary would keep a careful check on proposed and pending legislation relating to matters medical, matters in which the whole profession has a personal stake and interest.

For still another reason an able paid executive is especially desirable at this time. It is obvious to everyone that the national and world situation at the end of the war or even earlier will involve, indeed we may really say in involving, far reaching plans for changes in our social structure that directly impinge on the private practice of medicine. This is the time, par excellence, when the profession should be able to present its strongest front, when its organization and its ability to express and support its views should be sound and well developed. In the integration, development and expression of the ideas and desires of the physicians of the state and in maintaining constant touch with local and national affairs in these crucial times an executive secretary is certainly an essential.

The advantages of such an executive have been amply demonstrated in the past five years by the experience of the Providence Medical Association. Through the efforts of Mr. John Farrell, this district society has increased its value many times over —both to its own members and to the community. In addition to this through Mr. Farrell's efforts the Providence Association has accomplished many things on behalf of the State Society — things which, because of a lack of a secretary of its own, the State Society must otherwise have left undone.

In this connection Mr. Farrell has, at the request of this Committee, prepared the appended list of the activities that he has carried on for the State Society. (See Appendix A.)

The present situation, your Committee believes, is an anomalous one. In order properly to discharge its function, we believe the Rhode Island Medical Society should, through an executive officer of its own, carry on all the various phases of its work. Its executive office should maintain close touch with all its members through the district societies and thus bring an equal share of its benefits to its entire membership throughout the state.

With the above considerations in mind your Committee presents the following recommendations:

1. That the Rhode Island Medical Society employ an Executive Secretary.

2. That with the consent of the Providence Medical Association the position be offered to Mr. Farrell, Executive Secretary of the Providence Medical Association, according to the following plan: Mr. Farrell to serve as Executive Secretary of both organizations with the following division of his services: 70% to Rhode Island Medical Society, 30% to Providence Medical Association.

(a) A discussion of Mr. Farrell's qualifications for this position is really superfluous as is well known to the entire profession of this state. Mr. Farrell has, in the short time in which he has served the Providence Association, developed the work of the Association along so many lines that it would take a long time to recite them all. Suffice it to say that he has become one of the best known Executive Secretaries in the East and a leader in his field of work.

3. Salary. That the Rhode Island Medical Society offer Mr. Farrell $3500 and suggest to the Providence Medical Association that it pay Mr. Farrell according to the same scale, i.e. $1500, making a total salary of $5000 from the two organizations (if accepted by the Providence Medical Association).

(a) As has been suggested Mr. Farrell has already achieved great success in his work as Executive Secretary of the Providence Medical Association and it is not an overstatement to say that he has become very widely known and appreciated throughout the country. It is quite in line with natural course of events that he will be given opportunities for a broader field of work at a much higher salary than he is now receiving. In other words, to put it perfectly plainly, if we wish to keep John Farrell in Rhode Island we must, before others do it, give him a broader field of work and a higher salary or in the normal course of events he will go where he is more appreciated.

4. Further expenses. That reasonable additional funds be made available for the use of the Executive Secretary in employing necessary secretarial assistance and for travelling expenses in line of duty.

5. Additional income to finance the above recommendations.

(1) That the annual dues be raised from $10 to $20 a year.

(2) That a $5.00 additional wartime assessment be made against each member to compensate for the loss of income resulting from the absence of those who are in the armed forces.

(a) A tentative picture of the finances of the Rhode Island Medical Society with the suggested advance in dues is appended and shows that an ample balance will result which will cover the estimated cost of maintaining the executive office as planned. (See Appendix B.)

Resolution

In view of the foregoing your Committee begs to present the following resolution:

Resolved, That the House of Delegates of the Rhode Island Medical Society approve the foregoing recommendations and present them for adoption to the next meeting of the Society.

Respectfully submitted,

Emery M. Porter
William S. Streker
John Paul Jones
John F. Kenney
Alex M. Burgess, *Chairman*

REPORT OF THE COMMITTEE ON COMMERCIAL EXHIBITS

Negotiations with prospective exhibitors at the 1942 annual meeting were undertaken as usual during the month of January preceding the June meeting, and all available space was sold out early in March. The exhibits this year were set up in the basement of the Medical Society Building which greatly facilitated the physical operation of the Committee on Exhibits and also enabled the usual activities of the Medical Library to continue uninterrupted up to and throughout the meeting. Thirteen commercial firms were represented in the exhibits, and all exhibitors seemed unusually well pleased with the new arrangements for their displays. From contributions made to the Society by commercial exhibitors, the sum of $202.36 was turned over to the Treasurer after deducting all expenses involved in arranging and staging the displays.

As far as could be determined, transportation difficulties and other complications resulting from the fact that the nation was at war did not interfere with the commercial exhibits for 1942. The Committee wishes to call to the attention of the Society that the work of this Committee must be started at least six months prior to the scheduled meeting, at which time definite plans as to the time and place of the annual meeting and the exact location of exhibit space must be known. It should also be pointed out that this Committee has for the past several years been able to turn over to the Treasurer of the Society the cash profits of between $200.00 and $500.00 annually from contributions from exhibitors, and that in normal times were a great deal more space available for exhibits than is the case in the Medical Library a much greater income to the Society might be realized from this source.

Respectfully submitted,

Charles Bradley, M.D., *Chairman*
Committee on Exhibits 1942 Annual Meeting

BOOK REVIEW

THE YEAR BOOK OF GENERAL MEDICINE 1942. Cloth $3.00. pp. 844. The Year Book Publishers Inc., Chicago.

The 1942 Year Book of General Medicine, like its predecessors, is a syllabus containing abstracts of the year's most important developments in general medicine.

The book is divided into five chapters, each chapter edited by an expert in his field. To give a complete analysis of its contents, one would have to review each chapter in detail, a most difficult task, indeed. Suffice it to say that it is an excellent book, summarizing briefly, but adequately, the most important articles that appeared in the medical literature during the year.

One cannot, however, refrain from mentioning some of the high spots that are evident throughout the book.

The opening chapter summarizes briefly the important contributions in the field of Infectious Diseases, with particular emphasis on War Medicine, and Tropical Diseases. Considerable space is given to the literature dealing with the immunization problem against Typhus and Tetanus. The management of malaria, the virus diseases, as well as some of the lesser known infectious diseases is well covered. The therapeutic value of the Sulfonamides, its toxic manifestations and danger signals are properly evaluated. Even such substances as Gramacidin and Penicillin, which are still in the embryonic stage of scientific investigation, are introduced to the reader.

The subsequent chapters too, are crammed full of new and practical suggestions. The anemias are given proper attention. The experimental use of radio active phosphorus in leukemia is mentioned. The reader is also introduced to new conceptions in therapy, such as oral administration of salyrgan, theophylline combination in an enteric coated tablet for congestive heart failure, and the effect of intramuscular injections of testosterone propionate in angina pectoris.

This reviewer feels that the Year Book of General Medicine is a valuable book to have at one's disposal at all times. The subjects are well covered in a most concise, clear, and readable style.

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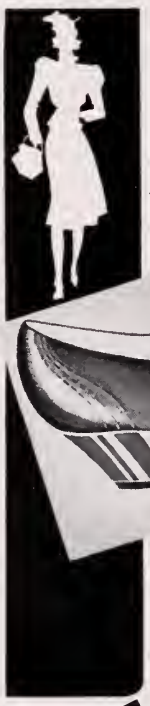
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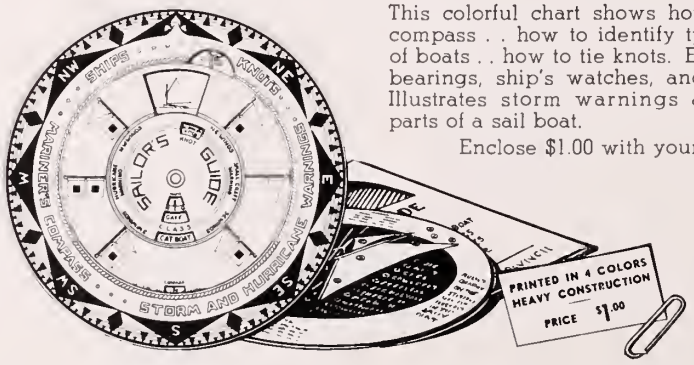


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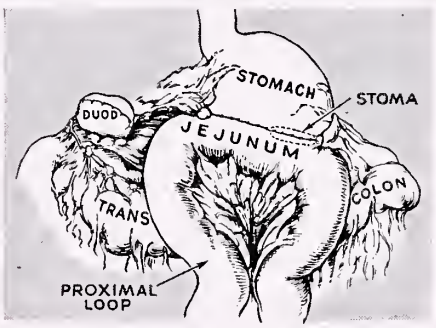
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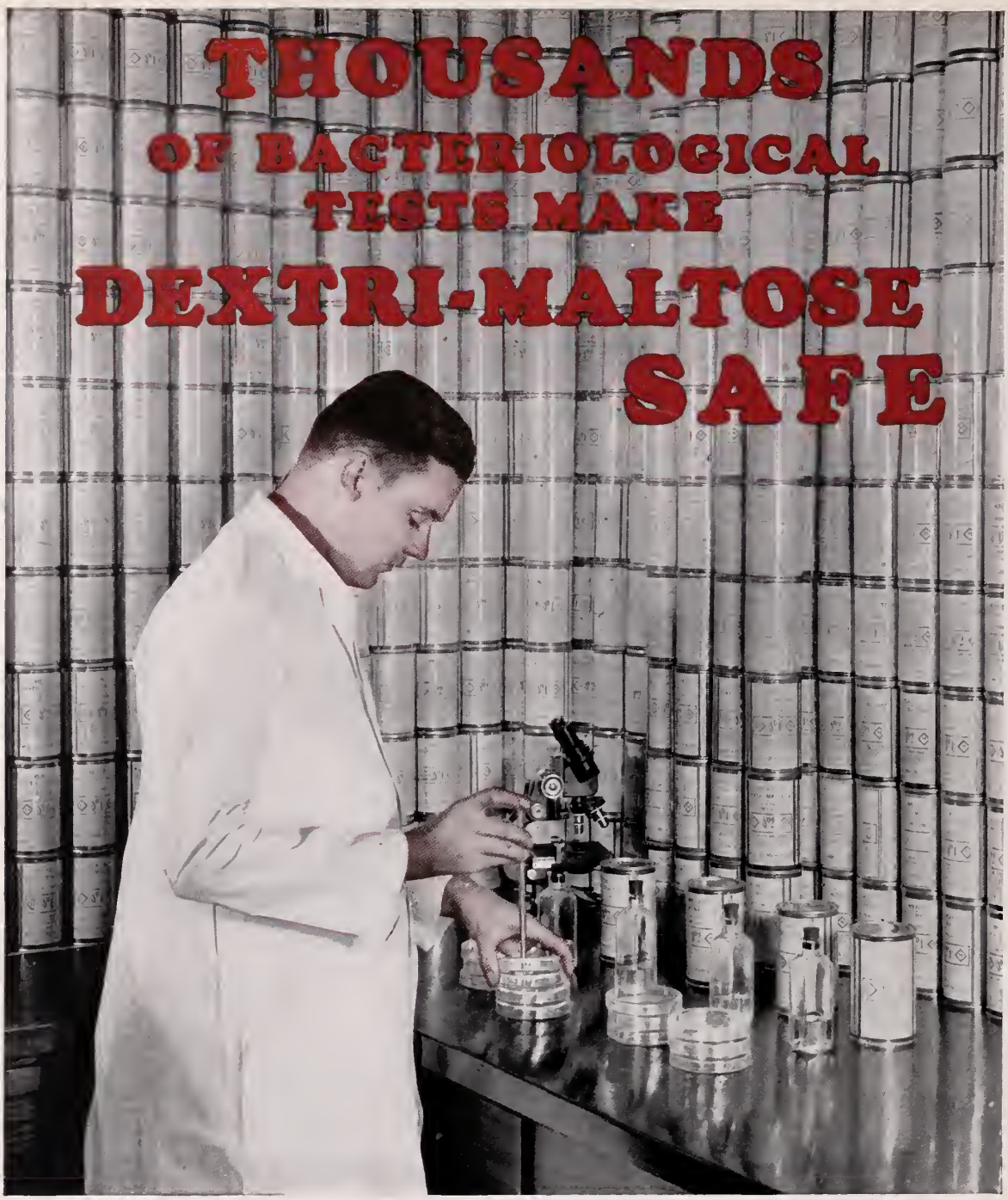
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1. *Fauley, G. B.; Freeman, S.; Ivy, A. C.; Atkinson, A. J.; and Wigodsky, H. S.;* Aluminum Phosphate in the Therapy of Peptic Ulcer. Arch. Int. Med. 67: 563-578 (March) 1941.
2. *Marshall, S. F., and Devine, J. W. Jr.;* Gastrojejunal Ulcer, S. Clin. North America, 743-761 (June) 1941.

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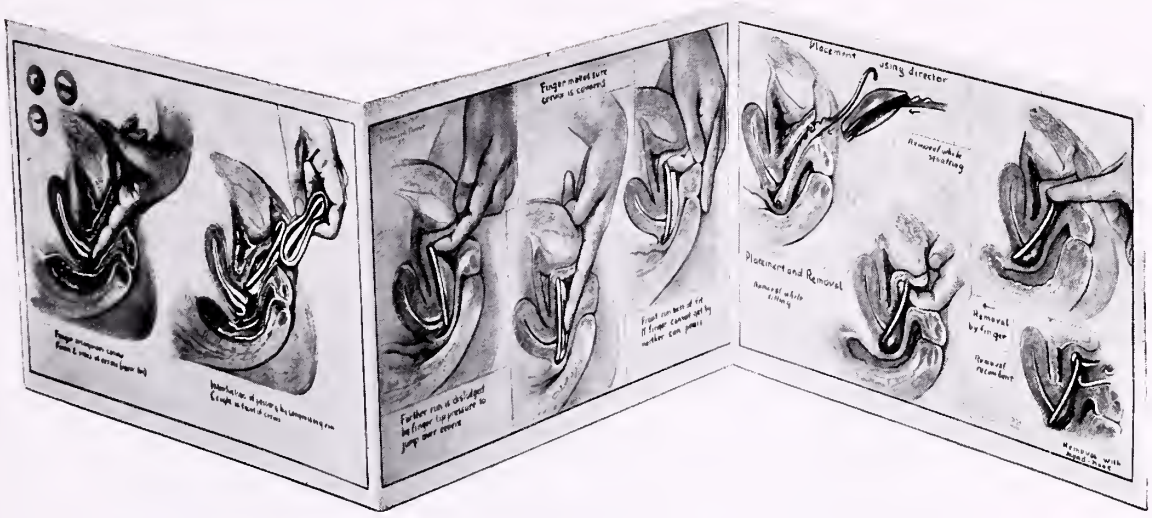
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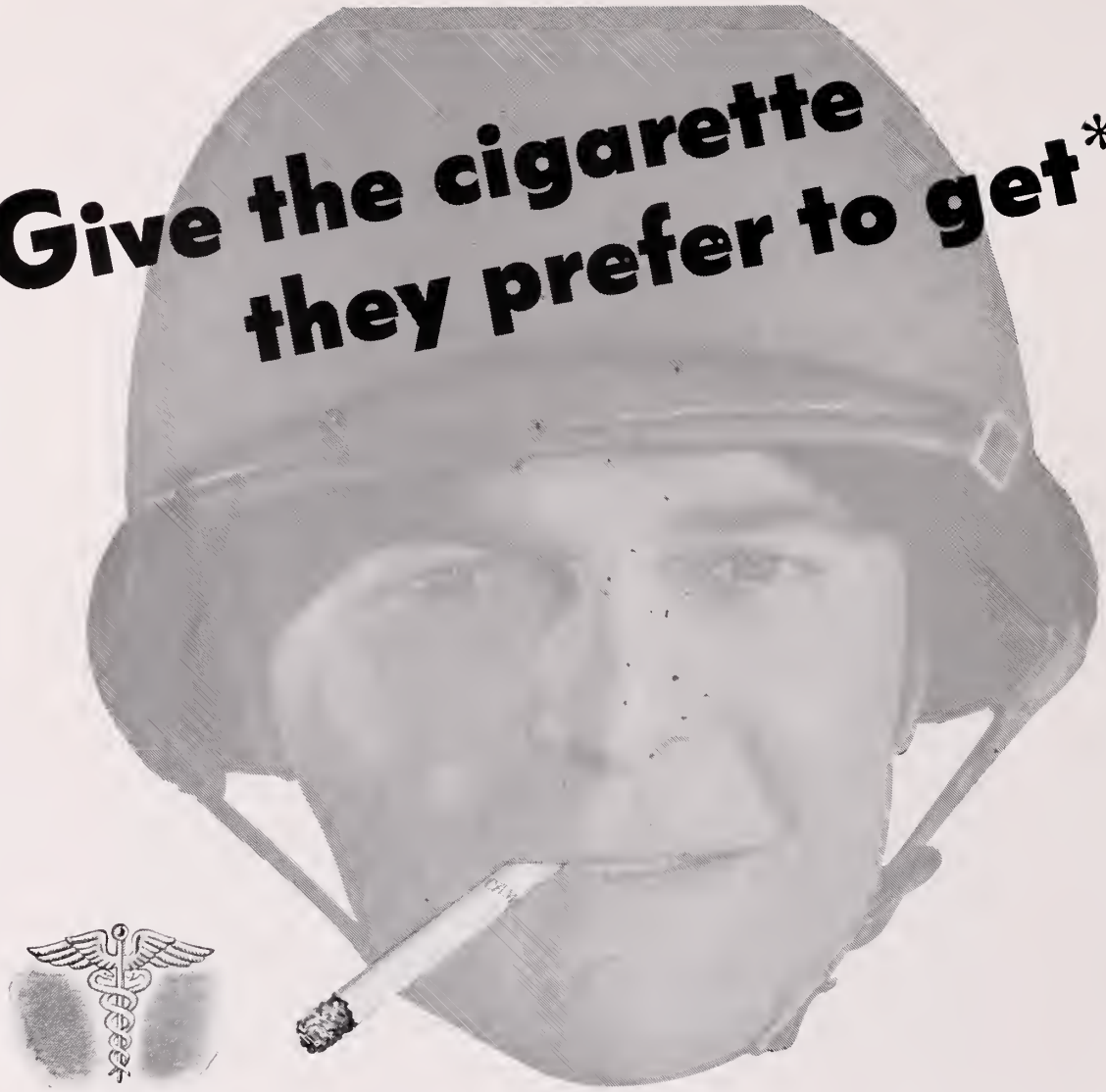
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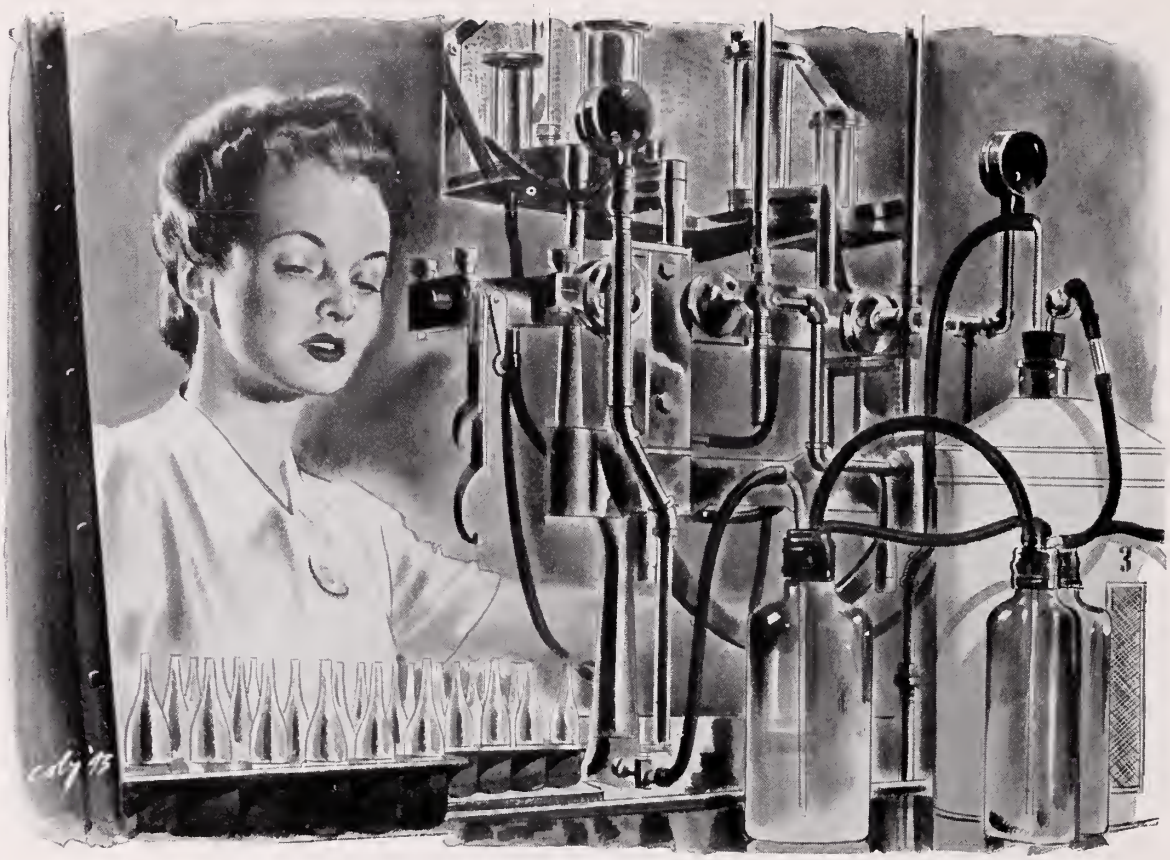
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THE RHODE ISLAND MEDICAL JOURNAL

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RHODE ISLAND CASH SICKNESS COMPENSATION ACT

Dr. Herman C. Pitts

Our much honored President has asked me to talk on the Rhode Island Cash Sickness Compensation Act. But to view this Act in its proper relation to the trend of other social legislation in this country and abroad it must be presented with a background of past and contemporary legislation in the same field.

We are, of course, most interested in the part medicine will be and is expected to play in this world of rapidly changing social relations. The State is taking on a greater control. We are being hemmed in more and more and the rights heretofore considered inalienable, promise to be taken away. The change has come rapidly too. Do you realize that it was not until 1892 that the State of Rhode Island began exercising any control of the practice of medicine? Before that time anyone with temerity to write "Doctor" before his name could practice on a gullible and unsuspecting public.

In the Rider Collection in the John Hay Library there is the reprint of an address delivered before this august body in June 1889 by Dr. George L. Collins, a man many of us remember, in which the writer decries the fact that the State was doing so little at that time to protect its citizens from the host of charlatans and illy trained so-called doctors that had reduced the practice of medicine in Rhode Island to the lowest ebb. Dr. Collins, of course, lived to see the State take the control it rightfully should, but I doubt if he in his generation ever dreamed that the pendulum would swing so far.

This whole movement for social betterment apparently stems from two sources. First the gradual increase in comfortable living has made the more fortunate ones more alive to the struggles of those less fortunate. In other words the whole world has become more humanitarian and in becoming so, various schemes have been proposed to lighten the lot of the poorer part of the population. The second factor has been the increasing insistent cry of labor for a larger share of the fruits of its labors. And along with this a demand for greater security in time of sickness and unemployment.

In times past it may have been verbally acknowledged that "the laborer is worthy of his hire," but capital saw to it that the amount of hire was kept down to a figure that made him doubly worthy of the little he received! All this was changed when labor organized, and the more completely labor organized, the greater its bargaining power regarding working hours, the amount of its remuneration and its right to be considered in the social scheme.

Strangely enough though, in the early days of social reform in this country it was labor itself that opposed legislation intended for its special benefit. In 1915 a Bill was presented in Congress calling for a system of compulsory insurance that planned protection for workers in time of sickness or unemployment. Opposition to the Bill came largely from the workers themselves. And although several redrafts of the Bill were made to do away with obvious objections, the opposition was so strong and well entrenched that all hope of national legislation along social lines was abandoned by 1918.

It is rather surprising that such opposition should have developed, in view of the well known fact that several European countries already had well-tried systems of Social Insurance that seemed to be working satisfactorily. Germany introduced such a system in 1883. Her lead was quickly followed by several other countries and finally by England with the Medical Act of 1911.

It is well to bear in mind that all of these earlier Acts were aimed at benefiting members of low income groups alone, while more recent legislation tends to bring all citizens, no matter what their financial status, into one great insured group.

Certainly the United States has lagged behind all other nations in social legislation. We have for years adopted a laissez faire attitude that has let private relief agencies take care of the more unfortunate portion of our population from funds subscribed by kindly disposed individuals. This system seemed to work fairly well until the Great Depression of 1929 put such a load on the private agencies that they were by no means able to relieve the acute distress that developed. Government was obliged to step in and once in has proceeded to try out various social experiments proposed by a group popularly known as the "New Dealers". There is no doubt that the seriousness of the situation gave a real justification for forcing through much untried and more or less theoretical legislation.

It was inevitable that some of this legislation should directly affect the medical profession. For there had been much grumbling over the high cost of medical care, but never any concerted effort by either Legislators or the Medical Profession itself to bring definite medical care to that portion of the public that sorely needed it and was unable to pay for it except at great sacrifice. A belief had grown up that health was a commodity that could be bought. That to be well, all one needed was a few dollars in one's pocket to pay some doctor for what was most to be desired. Unfortunately this is true to a certain limited extent.

It is a sad commentary on the intelligence of any group, be it the American Medical Association or any other, to have them say, "There is no medical problem in this country." For all of us know only too well that we are individually and constantly seeing patients who are debarred from competent diagnosis and proper treatment from lack of funds.

By and large the high standards of the medical profession are without question. We are willing to and do sacrifice ourselves constantly for the good of our fellow men. But after all we too are laborers working for hire and cannot be expected to act more than just so often as angels of mercy and financial agents at the same time!

It would be useless and far beyond the scope of this paper to argue the rights of labor to dictate or even suggest methods of social reform to our central Government. But labor is so firmly in the saddle that mere suggestions are listened to as never before by ears to the ground in Washington. The resolutions passed at a recent meeting of C. I. O. asking for national legislation to expand the benefits of Social Security and a more recent one of the American Federation of Labor asking for exactly the same thing, may have a tremendous effect on our labor minded administration.

Like an answer to these very resolutions, comes a Bill before Congress by our own Senator, Theodore Francis Green, which has for its purpose quite a large expansion of benefits under Social Security. By a slight increase in the contributions now called for, our workers are to secure freedom from fear and freedom from want as part of our War Aims. Among many other benefits free hospitalization is to be provided and when necessary re-habilitation service by qualified practitioners in Governmental and non-Governmental hospitals. The Bill does not state where the "qualified" doctors are to come from, and how they are to be paid. Very likely Senator Green and others are looking forward to the time when the pendulum of social reform having swung far enough, they can put through a bill such as the one proposed very recently in Australia. There a National Health and Medical Service scheme is under consideration. Under it all existing hospitals and health services would be taken over by the Federal Government. Some four thousand salaried doctors would be appointed and they would work in 460 medical centers. Their salaries would range from 26 to 52 hundred dollars per year—rather small sums, when the average gross income of medical men in Australia is given as 6850 dollars!

All of these newly fledged schemes seem to use the war as an excuse for their birth. We can grant that this last and worst of all wars is in a manner a revolution. Certainly the world will be greatly changed when it is over. But I doubt if there is any thought in the minds of the men who are giving their all to rid the world of the menace of Naziism, that they are engaged also in a real revolution in the field of social relations. Perhaps the war is stimu-

lating this sort of change more than we think. I have read, for instance, that the very radical Beveridge Report has been received with signs of approval in England largely because the middle and upper classes there have learned more of misery among their less fortunate countrymen from the evacuation of children from the large centers of population, than they ever dreamed of. Their sympathies have been aroused and they are willing to accept any scheme however Utopian that promises betterment.

Of all plans thus far proposed the one outlined by Beveridge and his associates is the most all-embracing. It is embodied in the report of the Inter-departmental Committee on Social Insurance and Allied Services appointed in June 1941 by the Minister without port-folio, then responsible for the consideration of reconstruction problems. Sir William Beveridge acted as Chairman of this committee. The report is voluminous. It would take hours to go over it in detail. What it is in substance can be expressed in these few words, viz:— "It is first and foremost, a plan of insurance—of giving in return for contributions, benefits up to subsistence level, as of right and without means test, so that individuals may build freely upon it." It plans to unify all now existing insurance schemes under one Government bureau, so that health insurance, cash sickness, benefit, unemployment benefit and the many others will be paid for by one weekly contribution. The plan literally covers all citizens from the cradle to the grave. A comprehensive health service is to be organized to give domiciliary and hospital treatment free and which is to carry on through re-habilitation until the individual is fitted to resume his or her occupation. Alas Sir William in his report fails to tell just what part the medical man is to play in all this. Details are to be left to the Minister of Health.

One recommendation made will certainly have the approval of all medical men. Cash benefit and medical benefit are once and for all divorced. In other words the doctor who treats the sick person is not made to certify to the illness in order that he, the sick person, may obtain his cash benefit. The English Panel Doctors have fought for this divorce for years.

One more item in the Report is of special interest. Private practice particularly in the specialties will go on if the Plan is accepted, but the field will become so narrowed that there will be less and less inducement to enter it. This implies without definitely stating it as a fact that practically the whole medical profession in England will become servants of the State.

With all these vast plans for social betterment springing up around us, can we possibly resist the contagion and be content with the many substitutes that are being tried on a small scale in various parts of our country? I say "we" in a large sense, for I do not believe that "we" in the restricted sense of the Medical Profession will have much to say about it. If enough of our individual States were sufficiently State-minded to introduce really radical social legislation of their own it might be possible to keep such legislation where it belongs, in the hands of the individual States. Such a thing does not seem possible. Here in Rhode Island we have made a start. Our new Cash Sickness Compensation Act is an opening wedge.

The Act was passed by the 1942 General Assembly and became effective May 10, 1942 although benefits will not begin until April 1, 1943. Rhode Island has the distinction of being the first State in the Union to embark on such an experiment and we may be sure that other States and the powers in Washington are watching the success or failure of our experiment with the greatest interest.

The object of the Act is to supply financial aid to workers whose earnings are lost through sickness. The influence of Labor is clearly shown in the inception of the Act. The State Unemployment Compensation Fund had grown to such size that Labor began agitating either for a lowering of contribution by employees or some sort of increased benefit. This agitation was fully justified. Because in the five States requiring employee contributions to the Unemployment Compensation Fund, Rhode Island workers pay a higher percentage than those in other States. And so to provide moneys for sickness compensation each employee shall contribute to the Rhode Island Cash Sickness Compensation Fund with respect to employment after June 1st, 1942 an amount equal to 1 per centum of his wages paid by his employer up to three thousand dollars in any calendar year. Each employer shall be responsible for withholding such contributions from the wages of employees at the time such wages are earned or paid. This one per cent is diverted from the 1½% that has heretofore gone to the Unemployment

Compensation Fund. The Act is administered by the present Unemployment Compensation Committee.

One per cent of funds collected are set aside for administrative purposes by law. This low cost would not be possible if the offices and administrative officers of the Unemployment Compensation Fund were not available for use in administering Sickness Compensation. Since all of these expenses are met by our Federal Government through funds provided by the Social Security Act it is evident that Sickness Compensation is not exclusively of Rhode Island, being suckled as well by a maternal Government.

Your Committee on Public Health meeting with the Committee to study the Rhode Island Cash Sickness Compensation Act of the Providence Medical Association in consultation with the Unemployment Compensation Commission pointed out to the Commission that in case the Federal Government withdrew its support, the 1% now alloted by law for administration would be totally insufficient to meet the cost, and suggested that an amendment be put through the Legislature allowing at least 4% of moneys collected to be used for administration.

The details of the administration of the Act are left entirely to the Unemployment Compensation Commission. There are two paragraphs in the Act that give them suggestions as to how to proceed. In sub-section (13) of Section 2, "an individual shall be deemed to be sick in any week in which, because of his physical or mental condition, he is unable to perform any services for wages." And again under Section 16, "This Act shall be construed liberally in aid of its declared purpose, which declared purpose is to lighten the burden which now falls on the unemployed worker and his family." There are other sections of course, in the act that are guides to the amount and duration of cash payments. The total amount of benefit to which a worker is eligible is determined by the total wage during a "base period" and this base period is defined as the calendar year immediately preceding the benefit year. That is, if an individual has earned only 100 dollars in the base period, cash compensation credits total only 34 dollars and this is paid out at the rate of $6.75 weekly until exhausted. If on the other hand the worker has earned 1800 or more dollars during the base period, the benefit credit is 364 dollars and 50 cents and this is paid out at the rate of 18 dollars weekly until exhausted and represents the highest weekly benefit under the Act. Intermediate amounts earned naturally entitle the worker to commensurate benefits. All this is clearly defined and easily followed.

How sickness is to be reported and by whom it is to be certified really constitute the difficult details that have been worked out by the Commission. Cards have been prepared with space for claimant's statement above and the attending physician's statement below. One of these cards properly filled out and signed must be sent in each week during which compensation is claimed. Right here we run into difficulties. How is "attending physician" to be interpreted? It necessarily must include osteopaths and chiropractors since they treat a very sizeable portion of our population and legally have nearly equal rights with men possessing an M.D. degree and again if the Act is to be interpreted liberally, it should include naturpaths, Christian Scientists and practitioners of other cults since members of their cults through error have periods of sickness just as the rest of us do. If this veritable hodge-podge of dealers in human illness are to have the right to certify sickness, what about reasonably scientific diagnosis? The data accumulated by the Commission concerning types of illness and seasonal illness will make very valuable statistics if properly handled, but will be of no earthly value unless diagnoses can be checked by some competent medical authority. With this in mind the Committees of the Rhode Island Medical Society and the Providence Medical Association meeting with the Unemployment Compensation Commission recommended that a full time Medical Director be secured to administer the sickness phase of the Act.

As I have said before, in the Beveridge Plan the attending doctor is not required to sign certificates for cash benefit. It is regrettable that some scheme for divorcing the two cannot be found for our Rhode Island Act.

As I look into the future, however, I must confess to a feeling that all these plans being put forward are merely temporary; that they are sure to be swept aside by something larger and more all-embracing. Refer back to the Bill introduced by Senator Green and remember what he says in justi-

fication of it, that by a slight increase of contribution to Social Security our workers will gain freedom from fear and freedom from want. The benefits given by Senator Green's Bill do not of course duplicate those given under the Rhode Island Sickness Compensation Act. Very soon, however, another Senator equally zealous to benefit his fellow men, will be asking for more amendments to the Social Security Act, calling for larger contributions to pay for the same benefits our workers are to receive under Sickness Compensation, and then alas the very laudable effort Rhode Island has made to maintain her independence in purely State affairs will be overshadowed by the greater power of the Federal Government.

The fate of all the other experiments being tried, such as the Blue Cross, the Blue Shield, the Michigan Medical Plan, the California Plan and a host of others will be the same. Their intent is most excellent, but their extent is insufficient to satisfy the wide enthusiasms of our experts in Social Security. No voluntary plan will satisfy their enthusiasms.

As a matter of fact voluntary insurance has never been successful wherever tried. The very ones the insurance is aimed to benefit do not join in any great number because the working man will not as a rule part with the least bit of his hard earned money to save himself from something that may never happen. Then too, voluntary insurance is one-sided in that the insurer pays all of the cost. If the insurer knows that capital and Government are sharing the costs with him, he *is* content to feel he is getting something for nothing. Something that he can demand and get and since he can demand it and get it, surely it is his by right. We hear the phrase "Wave of the Future." Someone has said that the wave of the future is the rising tide of labor, and that rising tide of labor will certainly be behind whatever in its opinion will bring the security it longs for.

The Medical Profession never has been and never can be an "organization in restraint of trade," in spite of the Court's ruling to the contrary. The best we can do, is to use our united influence in shaping future legislation so that some measure of the fine flavor of medical tradition will be left in the land.

68 Brown Street

THE TREATMENT OF PNEUMONIA WITH LARGE IMMEDIATE DOSES OF SULFONAMIDE WITHOUT COMPLICATIONS

JOHN F. KENNEY, M.D., F.A.C.P.

Read at November Meeting of Pawtucket Medical Association.

Since the publication of Evans and Gaisford of London and Long of Baltimore in 1938 and 1939, much has been written about the clinical properties and clinical results in the use of Sulfonamides together with the toxic dangers. Lately, articles are appearing advocating the use of large or small doses and particularly concerning the serious complications such as anuria resulting from the use of these drugs.

These same reports are put in such a way that they may do harm to the average practitioner without hospital associations, making him somewhat timid about using the drug or if he uses it, he has not the courage to carry out efficient treatment as the cases I have to report will show. Not that the dangers of these valuable drugs should not be brought to his attention; but considering the wonderful effects in pneumonia and how relatively infrequent these dangers are in comparison with the drugs used for other conditions, their use is indicated. It is with this thought in mind that I wish to report our experience at The Memorial Hospital, Pawtucket, R. I. Since 1939, we have treated over 350 pneumonias on all hospital services including private patients. On going over the records, I find, excluding nausea and vomiting which occur infrequently now with sulfadiazine, an occasional reporting of a rash or of *sulphur crystals* in urine, the only serious complication is one case of anuria; and this was not in a case of pneumonia and it is to be noted this blocking occurred with only a small dose of the drug.

During 1940, every case on medical service where practicable was given intravenous sodium sulfapyridine with no complication.

I wish to call attention also to a report of Rosenthal, MacColl and Joseph Pratt in the N. E. Journal of Medicine of May, 1942, of 130 cases treated at home without complications. Helwig and Reed of Kansas, J.A.M.A., June 13, 1942, report a fatal case of anuria following sulphadiazine therapy,

pointing out in this case that it was not a mechanical blocking of the tubules but that it is a tubular poison causing a degeneration of the tubular epithelium, and thus mere drainage will not relieve this condition. Lehr, they point out, carried out experiments on albino rats and found that sulfadiazine may produce an acute precipitate of free drug in the renal tubules and because of the poor solubility of the drug cause a severe degeneration of the tubules.

Case No. 1:—Mrs. E. K.—American—Married—Occupation: Mill Inspector—Age: 28—(Case seen in consultation by me seven days after admission.)

Admission Diagnosis: Pneumonia. *Admission Date:* June 1, 1942.

Chief Complaint: Cough and fever.

Past history and family history: Irrelevant.

Present Illness: Patient complained of a sore throat one week ago with a cough of two days. Later she had a chill and fever with pain in the left chest and moderate amount of dyspnea. Stayed in bed at home for 2 days and hospitalized.

Physical examination: Negative except for chest. Dullness over left chest posteriorly from scapula down with slight increase in voice sounds. Moist rales heard in both lungs but especially the left lung in the upper lobe. W.B.C. on admission 19,500. 79% polynuclears. *Sputum:* Few organisms resembling pneumococci, type not determined. All other laboratory procedures were negative. *X-ray Report:* June 2, 1942—Scattered infiltration throughout the lower two-thirds of left chest and to a slight extent in the right lung. The x-ray interpretation noted that while the changes may have been due to a disseminated pneumonia, nevertheless, the infiltrations especially on the left side were somewhat suggestive of a pulmonary, military type, of tuberculosis.

Continued sputum examinations were negative for tuberculosis. Sulphadiazine was instituted on admission, 7.7 grs. every 3 hours, by attending physician but temperature continued to 101 degrees and 103. I was asked to see the case and on physical examination did not feel that it was tuberculosis. Signs, symptoms and history pointed to pneumonia and an insufficient amount of sulphanomid drug. On June 7, 250 grs. were given in the first 24 hours followed by 100 grs. in the next 24 hours. Level rose from 2.1 on June 7 to 17 mgms. on June 8, and remained above 8 until June 11th. The temperature became normal on June 11 and the patient's condition markedly improved. She was discharged on June 18th. X-ray report on June 16 now showed complete resolution of the disseminated process in both lungs with a very slight residue in the left base. Final x-ray diagnosis was a pneumonic process and not a tuberculous.

Case No. 2:—Miss N. J.—Age 25—Stenographer. Admitted: 2/28/42. Sent to private service of Dr. J. F. K. with diagnosis of cardiac condition, and pneumonia.

Admission Diagnosis: Lobar Pneumonia.

Chief complaint: Cold, 5 days.

Past history and family history—irrelevant.

Present illness: 5 days before entry, patient developed a cough and mucus but no sputum since the first day. Chilly sensations and marked shortness of breath. Headaches and constipated.

Physical examination: Negative except for chest. Chest: Movements equal but labored. Question of slight dullness over scapular region in right. Breath sounds not decreased. Occasional wheeze. Fremitus normal.

X-ray on admission showed right upper lobe pneumonia. Temperature on admission was over 105. Patient had been given small doses of sulfathiazole by an attending doctor on the outside. Sulfadiazine 421 grams given in 30 hours. Sulfadiazine level of 11.6 mgms. obtained in 24 hours and a level about 8 maintained from 2/28/42 to 3/5/42 when temperature reached normal. Urine showed sulfa crystals on 3/6/42. X-ray report on 3/9/42: Re-examination of the chest, compared with the previous examination made 2/24/42 now shows almost complete resolution of the pneumonic process in the right upper lobe with only a slight residual infiltration. Patient discharged as recovered on 3/12/42.

Case No. 3:—S. M.—Widower—Retired—Age 59—*Admission Diagnosis:* Diabetes. Lobar Pneumonia. Case seen in consultation by Dr. J. F. K. on April 16, 1942.

Chief complaint: Difficulty in breathing. Diabetes.

Past History: Diabetes for years. *Family history:* Irrelevant.

Present illness: Patient states that he has had diabetes for years and taking protamine insuline. He has been nervously and emotionally upset recently and started to cough up phlegm and run a temperature.

Physical examination: Well developed and nourished white male, lying in bed, slightly dyspneic. Remainder of physical examination negative except for chest. Respiratory movements are free and equal. Question of dullness over left upper chest posteriorly. Exaggerated breath sounds over left upper chest anteriorly and posteriorly. Diminished resonance over the same area. Diagnosis: Left Lobar Pneumonia.

W. B. C. 9,650; 81% polys. Urine sugar and acetone. Sputum: large number of pneumococci but type not determined. (He had been given small doses of sulfathiazole before admission.) Blood sugar 119. X-ray report: Examination shows considerable haziness of left chest with slight elevation of diaphragm and apparently some displacement of mediastinum. Question of some degree of atelectasis of left lung principally of left upper lobe. Temperature on admission 100 degrees and it dropped to normal the next day, remaining around 99 and on the 5th day went to 100. On the 7th and 8th days, 375 grs. of sulfadiazine given. Temperature went to 103 and then down to normal and remained so until patient was discharged. A level of sulpha at about 14 mgms. was maintained for several days. Urine on discharge: Negative albumin. Sugar, Acetone 0. Blood sugar 125 mgms. on 30 units of protamine insuline.

Case No. 4:—Mr. L. W. P.—Married—Age 31—Machinist—Sent to the private service of Dr. J. F. K. on May 11, 1942. *Admission Diagnosis:* Lobar Pneumonia.

Chief complaint: Pain in the right chest. Fever of 10 days' duration.

Family history: Irrelevant. *Past history:* Pneumonia 10 years ago.

Present illness: Patient states that he was perfectly well until 10 days ago when he began to feel weak and tired. The following day he went to work but had to come home. He began to have pain in his right side and was feverish. He called his own doctor who gave him pills. Two days later, he called in another doctor who treated him for a week and then called in the present attending physician as a consultant. It was agreed that the patient should be hospitalized.

Physical examination: Well developed and nourished male in bed, with some discomfort. Remainder of physical examination negative except for chest. Symmetrical. Slight limitation of motion at right base. Dullness over the right base on percussion. Bronchial breathing over the same area with fine crepitant rales. *Diagnosis:* Right Lobar Pneumonia.

W. B. C. 16,550. 91% polys. Sputum: Few pneumococci. Streptococci predominated. X-ray report on admission: Shows haziness of base where diaphragm is partially obscured. The findings suggest pleurisy at left base possibly associated with a very small amount of fluid but no evidence of consolidation. Re-examination by x-ray, 8 days later, compared with the previous examination made 5/11/42 now shows complete absorption of haziness and suspected infiltration at right base. Patient's temperature on admission was 103.5 and as far as could be determined he had received about 200 grs. of sulfathiazole over a period of 10 days on the outside. We started him on sulfadiazine and he received 475 grs. over 48 hours to maintain a level of 11.2 mgms. for several days. The patient's temperature became normal in 48 hours and remained normal until discharge.

Case No. 5:—H. M.—Age 15—Student. Admitted 5/5/42. Discharged 5/16/42.

Admission Diagnosis: Medical Observation. (Patient seen in consultation.)

Chief complaint: Headache. Backache and fever for the past 4 days. Inability to urinate for two days.

Past history and family history: Irrelevant.

Present illness: Patient states that he was well until 4 days ago when he developed a severe headache (over entire head) and a backache in lumbar region. He became feverish and his L. M. D. was called who after an examination gave him pills without result. Patient became worse and his own doctor took him into hospital as his private patient.

Physical examination: Negative except for chest and abdomen. Expansion is slightly limited in right base. Dullness and diminished breath sounds over right lower chest with fine crepitant rales. Left lung clear. Abdomen: Rounded mass, dull to percussion, extending 3 inches above pubes, appears to be a distended bladder. Diagnosis: Right lower lobe pneumonia. Urinary Retention.

X-ray of chest shows a number of infiltrations in right lower lung extending downwards and upwards from the right hilus, consistent with presence of a pneumonic process at right lower lobe. W. B. C. 11,000; 88% polys. Urine: Specific gravity 1.010; very slightest possible trace of albumin; leucocytes. Patient was started by attending physician on sulfathiazole grs. XV every 4 hours for 3 days and a level of 2.8 mgms. obtained on 5/8/42. Case seen in consultation on 5/8/42. 390 grains of sulfadiazine given in the following 36 hours, bringing up the level first to 8, then to 17.6 and maintained for 48 hours at 14 mgms. Temperature dropped from 102 which had been maintained for first 5 days after admission to normal on 5/10/42 and remained normal until discharge. No pneumococci found in sputum after admission to hospital. Urine and blood normal on discharge 5/16/42.

Case No. 6:—J. D.—Age: 19—Occupation: Back Tender. Admitted March 11, 1942. *Diagnosis:* Infection of skin and underlying tissue of right hand. Case seen in consultation with attending surgeon.

Chief complaint: Injury to the right hand. This was following an accidental crushing of the hand in a press, causing a compound fracture with a deformity of the proximal phalanx of the ring finger. Patient was discharged on April 6, 1942. Re-admitted on April 12, 1942 for repair work of the finger. Re-admitted on May 4th with the area on the finger draining pus, swollen and painful. On 5/8/42, the attending surgeon started sulfathiazole treatment, grs. XV every 4 hours. Condition became very poor. A level of only 2.8 was obtained. On 5/10/42, there was a complete suppression of urine. Blood chemistry showed a creatinine of 4.6, whereas, a previous blood chemistry done on 5/5/42 was normal. The usual treatment, packs, clyses, blood transfusion, together with catheterization of both ureters, was carried out. The temperature was normal from the 15th and the patient was discharged on 5/27/42 with a normal blood count and normal blood chemistry. Discharged improved.

COMMENT: A large number of cases of pneumonia have been treated by a number of physicians without any serious complication. Blood level is no criterion as to complications such as anuria, and blood level determinations should be encouraged, more to be sure that enough drug is being given rather than for a check on any toxicity. This is shown by low levels for first few days in the above reported cases, and the small doses and low level in the one case of complications reported. I feel that large amount of fluids should be given continually. The findings of crystals in urine should not be an indication to discontinue the drug.

The six cases reported were taken from my private service. There are many others from ward service. These were selected as cases which I personally followed.

Complications occur with small doses of the drug as well as with large doses but as stated previously, we have not had these occur with large doses. Cases, however, have been reported with larger doses. The giving of such large doses in a short time and the immediate discontinuance of the drug, instead of somewhat smaller doses with a gradual decrease may be open to debate. In favor of the former is our giving the drug (sodium sulphapyridine) intravenously during 1940 without complications.

209 Broadway, Pawtucket, R. I.

The late Dr. James W. Leech did many tonsillectomies in his day. When he was somewhere around fifty years of age he had to have his own tonsils removed. While convalescing in the hospital he asked to have the head operating nurse sent to his room. He said to her, "Miss Potter, I wish hereafter to make a change in my operating technique." "Yes, Dr. Leech." "From now on when you set out my instruments please see that there is a large sterile handkerchief on the table. For when it comes over me how that poor patient's throat is going to feel in a few days I am going to burst into tears."



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MEDICAL MEETINGS FOR 1943

The annual meetings of most of the national medical organizations have been canceled for 1943. This step has apparently been taken in most cases to ease the difficult transportation problems which our country is facing. In many instances the number of medical men in military service who will be unable to attend meetings is another reason for not planning such gatherings this year.

All of us who have been accustomed to the periodic stimulation and inspiration of gathering with our colleagues will feel the lack of these meetings this year. In spite of increased work for everyone and with diminishing opportunities for rest and relaxation, medical men can hardly afford to forego all professional meetings. This situation should make our local meetings for 1943 of increased significance to us, and the meetings of the district societies and the State Medical Society should enjoy a proportionately large attendance from members who are not away in military service.

The time and effort which go into the planning of any medical meeting impose a significant burden on the officers of all medical societies. The officers of our district and state societies are in most instances by virtue of their prominence in the profession already carrying more than their share of the medical work in our various communities. If they can devote the time and energy required in planning medical meetings, the rest of us can certainly give them our enthusiastic support by attending the gatherings and taking an active part in the programs and in the discussions.

The Rhode Island Medical Society will hold an annual meeting at the usual time this year. Presumably the program and other arrangements will be somewhat contracted for reasons that need no explanation. All members who are in better than tolerable physical health and who are not actually away on war missions should not fail to attend. The program will be worth your while, and your attendance will counteract any discouragement that may accompany organized medical activities in these troublous times.

RHODE ISLAND HOSPITAL UNIT IN INDIA

Not long ago we learned that the Unit was on the Pacific coast. Now news has been received of them in India. By what devious routes they travelled has not been disclosed. Presumably in the days before the world went haywire a group of Providence people desiring to see the land of tigers, elephants and the Taj Mahal would have ferried over to England, there taken the P. & O. steamer, stopping at Gibraltar and pleasant Mediterranean ports, then through Suez and the Red Sea. It would have been a few weeks trip marked principally by three square meals daily with tiffin, tea and numerous high balls;—pleasure associated with ennui.

But we have reason to believe this strikingly different. Where they disappeared to after sailing out into the Pacific it seems useless to conjecture. But we know that wherever they went they were in danger. The mere fact that they were doctors

and nurses whose sole duty was to help sick or wounded humans gave them no immunity whatsoever. This is a terribly logical war. The Japs and Germans are out to destroy all their enemies possible. Anyone working to save any of these enemies is hindering their purpose. So medical units on errands of mercy are as fair game as fighting forces.

But the families and friends of these officers and nurses are justified in heaving sighs of relief. To be off the seas and on the solid earth of India is to have one of their gravest perils disposed of.

As to where they go from there;—one guess is as good as another. Not being a radio commentator we can speak with no semblance of authority.

Let us trust they follow advancing troops steadily towards Tokyo.

CLINICAL PATHOLOGICAL CONFERENCE

at Meeting of

PROVIDENCE MEDICAL ASSOCIATION

March 1, 1943

Case presented by

ANTHONY V. MIGLIACCIO, M.D.

Patient: Age: 78. Admitted: January 18, 1943. Discharged: February 2, 1943.

Chief Complaint: Epigastric pain and vomiting for five days' duration.

Present Illness: Suddenly five days ago, patient began to have severe epigastric colicky pain, which was also felt at a point three inches below the scapula on the right. Vomiting has been a constant feature and changed from a greenish color and bitter, to a dark-brown fecal-smelling material. The pain does not radiate and is attended with much gas. Change in body position does not help the symptoms. L. M. D. has had to give her six morphine injections during the past five days.

Past History: Thirty-five years ago had her ovaries, uterus and appendix removed. Remained well until two years ago when she had a spell of vomiting due to a gall stone, which was dissolved by L. M. D. She was admitted to the hospital and went home in one day at that time.

Following this episode the patient had to watch her diet. She avoided red meat, eggs, milk, butter, fried foods, pork and sweets. Cereals, vegetables and fruit were well tolerated.

Beginning one year ago she began to have epigastric pain but this was different from the pain experienced two years previously in that the pain and vomiting were more severe and more persistent. These attacks have recurred several times since. Has never noted the color of bowel movements.

Systematic Review: Negative.

Family History: Mother and father died of tuberculosis.

Physical Examination: An elderly widow who looks her stated age, having paroxysm of acute epigastric distress with vomiting. *Heart:* Normal sinus rhythm. Heart sounds difficult to hear but apparently no murmurs. *Blood Pressure:* 95.75. *Abdomen:* Large obese abdomen which is very soft—no spasm present. Tenderness present in the right costovertebral angle and in the epigastric area. There is some tenderness in both upper quadrants on deep palpation. Liver, spleen and kidneys not palpable. No hernia present. The patient was moderately tender to deep palpation at the tip of the xyphoid process. She states—she feels a fullness in her midepigastrium as if something were stuck there in her throat, with the material moving up and down.

Auscultation of Abdomen: Peristalsis moderately active. *Percussion of Abdomen:* Slightly tympanitic. No fluid wave or shifting dullness. There was no jaundice. Otherwise the examination was negative.

Laboratory Work:

Hinton: Negative

Hgb. 15.3 gms

W. B. C.

1-19-43 9,000

1-28-43 14,500

	1-19-43	1-26-43	1-30-43
Urea Nitrogen	69	29	43
Creatinine	4.3	3.0	3.1
Glucose	99	92	
Phosphatase Acid	2.7 K. A units per 100 cc		
Alkaline	6.7 K. A units per 100 cc		

3 urine exams not remarkable. Specific gravity 1015, 1015, 1016.

X-ray January 18, 1943: The chest shows no active pathology in the lungs. The diaphragm shadows are of normal outline and there is no fluid in the pleural cavity. Heart and vessels are not enlarged but there is slight flattening of the heart due to elevation of the left diaphragm. Upright film of the abdomen is unsatisfactory due to the patient's condition. There is a large sharply delineated, dense shadow, just above the crux of the diaphragm. There is a fluid level within this shadow which is consistent with diaphragmatic hernia.

X-ray January 28, 1943: Beside examination of the abdomen shows the Miller Abbott tube well beyond the stomach, and the distal end of the tube is in the jejunum.

Progress: The patient was admitted on the Medical Service on January 18, 1943. A Miller Abbott tube was inserted. Intravenous fluid was given, and a generally supportive regime was instituted.

The following day January 19th the patient was transferred to the II Surgical Service for a possible small bowel obstruction.

Surgical Note: January 23, 1943: Patient has stopped vomiting. Fecal character of vomitus would lead one to suspect intestinal obstruction. On examination, however, abdomen is soft and not tender, there is no hyperperistalsis. Has had poor results from enemas. X-ray shows a diaphragmatic hernia. Blood chemistry shows evidence of uremia. Vomiting could be due to both the uremia and the hernia but one would not suspect fecal vomiting in either. However patient is in no condition for surgery. Suggest medical treatment temporarily. Patient transferred to Medical Service. She pulled out the Miller Abbott tube. The blood chemistry showed improvement. Vomiting started again, and on January 27th was fecal in character again. The Miller Abbott tube was reinserted and fecal vomiting stopped.

Surgical Consultation: January 28, 1943: We feel that the vomiting is from a surgical mechanical condition. It may come from the diaphragmatic hernia but this is improbable. It may come from adhesions from previous operation. Do not believe that this patient will stand surgery at this time. Blood chemistry has improved slightly. Continue with Miller Abbott tube, fluids, etc. at this time. If condition changes for the better will consider operation later.

Medical Note: February 1, 1943: This patient is not improving. She is still having fecal vomiting. Her kidneys may show some failure but there is no albuminuria, and specific gravity of 1.016 is noted. I think that this is a surgical problem and that if her vascular collapse can be overcome, she should be operated. Today her blood pressure is 96/82 right and 80/72 left, as far as can be determined. She is duller and weaker this morning.

February 2, 1943: Blood transfusion was to be given. As the interne was about to do a venesection the patient took a few gasps and expired.

Discharge Diagnosis: (1) Intestinal obstruction due to undetermined cause. (2) Hiatus hernia.

This case presents many interesting angles. First, one wonders why the patient was not admitted to the hospital earlier. Persistent vomiting and pain which required morphia hypodermically, so frequently, surely are definite indications for hospitalization. It may be that the patient refused.

On admission, the diagnosis of intestinal obstruction is quite obvious. The cause of the obstruction, however, is the mystery. The x-rays are portable plates and, because of the patient's obesity, are poor. One can't tell whether there is small bowel distension or not. Neither can one see gas in the large bowel. Either one of these findings would help in localizing the lesion. If one was certain that there was gas in the colon, then it would be natural to suspect a malignancy of the large bowel. Without any gas in the large bowel, plus distended small bowel, then suspicion would be centered on the small bowel.

Because of the absence of fever, localized tenderness and because of the low white blood count, an acute inflammatory process seems unlikely, although in the aged this is not always so.

The x-ray findings of a diaphragmatic hernia does not make the problem any easier. Apparently the stomach is the only organ involved in the hernia. Could it be possible that there is a kinking or twisting of the transverse colon, as it is dragged up by the stomach? The diaphragmatic hernia undoubtedly has been present for years, as there is no history of accident, which could have caused this recently.

If this assumption is correct, then it is only natural to assume that the hernia should have caused more trouble in the past, than it has, and that decompression of the stomach should have relieved the obstruction. Because of these factors, I feel that the hernia is only an incidental finding and has no bearing on this case.

The high urea nitrogen and creatinine, in an old woman, show that there is some kidney damage. The medical note seems to indicate otherwise, but the fixation of the specific gravity of three urines (1.015, 1.015 and 1.016) make me wonder. With uremia, vomiting is common but fecal vomiting is rare. The blood findings are probably partly due to the electrolyte and water loss associated with the vomiting. The improvement from 69 mgm. to 29 mgm. of urea nitrogen, noted with the institution of corrective measures, bears this point out. Even though the same measures were continued, the urea nitrogen rose from 29 to 43 mgm. The creatinine was constantly elevated. These factors undoubtedly are indicative of underlying renal pathology. The absence of hyperperistalsis usually found in intestinal obstruction, makes it probable that there is at least an underlying paralytic ileus. This is found in uremia, but it is also encountered in mechanical obstruction, which has existed for some time, where the bowel finally tires out. The latter seems to be the more reasonable of the two, in this case.

Because of the patient's age (78) and the persistent low blood pressure, some cardiac damage is to be expected.

The absence of: 1. anemia; 2. history of diarrhea; 3. loss of weight, plus sudden onset of the present illness, rules out a lesion in the right colon. With lesions of the left colon, vomiting is a late manifestation, and severe pain is unusual, except in a ruptured diverticulitis, which has already been ruled out.

Retroperitoneal lesions such as sarcoma, which creeps in between the peritoneal layers of the mesentery, and then encroaches on the bowel lumen, must be thought of but are quite rare.

This leaves us only with the small bowel. The lesion must be in the ileum or otherwise the vomitus would not be fecal in character. Meckel's diverticulum, polyp, or carcinoma, would be more apt to give, at the start, an incomplete or intermittent obstruction. Intussusception of nineteen days' duration, without more signs of an acute abdomen, seems improbable. The same can be said of volvulus or mesenteric thrombosis. I have never seen a so-called internal hernia. A Richter's hernia would have cause more localizing signs. The old history of gall bladder disease, the pain at onset, which was localized to scapula, as well as in the epigastrium, plus the suggestion of tenderness in the upper abdomen, make one ponder over the possibility of an obstruction due to a gall stone; but here again one is overcome by its rarity. This thought reminds me of a case which the late Dr. Henry Hoye had in 1929, of intestinal obstruction in a patient like the present one, who was in very poor physical condition. After five or six days of prayer and enemas, the nurses and the doctor were rewarded with three beautifully facetted stones. These stones were proudly displayed in the Staff Room at the R. I. Hospital. To clinch the diagnosis, Dr. Hoye was prevailed upon to have the stones examined. Dr. Clarke found that they were fecaliths and not gall stones. This too, seems improbable.

Now, remembering that a "thing is most apt to be what it is most apt to be" we come to the most probable diagnosis, and that is obstruction of the terminal ileum due to adhesions from the old pelvic operation. This diagnosis is arrived at by exclusion and like most diagnoses so made, is probably wrong. Remember that the patient also has: 1. Chronic myocarditis; 2. Chronic nephritis; 3. Diaphragmatic hernia.

Discussion

Dr. Burgess: I don't think the patient had nephritis. All the findings pointing to that could be due to intestinal obstruction and vomiting. There were not enough urine exams to be of value but I think uremia can be ruled out. The patient apparently was in continuous shock and not in shape for surgery.

Dr. Jesse Eddy: There were no biliary tests done and I think they should have had some. The fact that the patient lived for sixteen days while vomiting showed she was strong. She lost large amounts of electrolytes and fluids. I think she should have had more x-ray studies. She evidently had intestinal obstruction.

Dr. Benjamin: The prevalence of gall stone ileus should not be ignored. We had three proven cases at the Memorial Hospital in nineteen months. The diagnosis should be made by x-ray.

Dr. Martineau: The x-rays in this case had to be bedside exams. She was markedly obese with a big apron of fat which obliterated the findings.

Dr. Harrington: This patient could have had a thrombosis of the mesenteric artery as the low blood pressure would predispose to this.

Dr. Butler: A barium examination would have cleared up the problem of the contents of the diaphragmatic hernia and told whether the colon was included. Gall stone ileus is not uncommon.

Dr. Migliaccio: There is a good article on gall stone ileus in a recent number of the American Journal of Surgery. These are rarely visualized in the small intestine. There is a big mortality associated with it. You must understand that this patient came in practically moribund and pulled out the Miller Abbott tube which we had inserted interferring thus with our treatment and plan of investigation. I feel that biliary tests are now generally considered of little value. They might as well be thrown out the window.

Dr. Batchelder: Only three percent of gall stones are calcified. Therefore they are rarely visualized in the small intestine.

Dr. Clarke: What do you consider the cause of the dramatic terminal episode?

Dr. Migliaccio: I can't explain this. She was very sick and anything might have happened.

Dr. Clarke's Discussion: The terminal event proved to be a pulmonary embolus. There was a thrombus riding the bifurcation of the pulmonary artery. It was about six inches long and its calibre indicated that it probably came from a femoral vein.

There was no evidence of chronic nephritis. The changes in blood chemistry can be best explained on the basis of high intestinal obstruction with vomiting.

Neither was there any important heart lesion. There was much fat in the epicardium and some fatty infiltration of the myo cardium. There was a mural thrombus on the lining of the right ventricle. Her condition of dehydration probably predisposed to thrombus formation since under such conditions the specific gravity of the blood is raised, it becomes viscid and the rate of circulation is markedly slowed.

The upper eight feet of the jejunum was distended and its wall congested and edematous. Below this it was collapsed and empty. At this point of obstruction the lumen was occupied by an egg shaped gall stone 3.5 cm. in diameter. There were many old fibrous adhesions between the gall bladder and the duodenum. When the gall bladder was opened there was found to be a large communication between it and the lumen of the duodenum.

Diagnosis:

1) Chronic cholecystitis.
2) Cholelithiasis.
3) Cholecysto-duodenal fistula.
4) Intestinal obstruction (gall stone).
5) Pulmonary embolism (terminal).

NEWPORT COUNTY MEDICAL SOCIETY

The regular meeting of the Newport County Medical Society was held on Tuesday night, February 23rd, at 8:30 at the Newport Hospital Auditorium. Dr. Louis E. Burns, president, presided.

Dr. William P. Buffum of the Rhode Island State Society was presented, and gave a short talk on the new set-up of the Rhode Island Medical Society. He mentioned that new by-laws had been adopted whereby members, becoming members of local Medical Societies would automatically be eligible for membership in the Rhode Island State Society upon payment of the usual State dues. It was also stated that members of the State Society beginning July 1943 would have a $15 war tax imposed yearly to make up the deficit in the treasury due to the remittance of dues of members serving in the Armed Forces. Dr. Buffum's statement seemed to meet with approval.

The speaker of the evening was then introduced as Captain George Eckert, M.C.U.S.N., Executive Officer of the Newport Naval Hospital. Dr. Eckert was on the hospital ship in Pearl Harbor during the infamous bombing of December 7, 1941.

The speaker said all types of war wounds were received on the hospital ship during the bombing itself, but that they were expeditely sorted under

these unusual circumstances. Shock seems to be the greatest cause of death in war wounds, particularly those occurring 8 to 12 hours immediately after. Three types of shock:

Primary, the first 8 to 12 hours, usually due to loss of plasma.

Secondary, anywhere up to 2 days, when hemoconcentration is present.

Third degree, which is not common, which is, nevertheless, the worst of all, and the hemoconcentration is more severe.

It was found important to give all patients morphine sulp. gr. ½, immediately, as this prevented psychic trauma to a great extent; this, of course, particularly during air raids, bombing, etc. All patients were given anywhere from 500 to 1000 cc intravenous plasma, and this was repeated later if found necessary. Plasma very important in the burned cases. Blood transfusions were given for the usual secondary anemias. Most of the cases were sprayed with 10% tannic acid until a firm eschar was formed. Some were painted with a 2% silver nitrate solution after the first coat of tannic acid. Silver nitrate was used mostly on cases which were losing fluid rapidly.

Due to the unusual circumstances present, it was impossible to observe sterile technique or to follow through with laboratory work. But the results were good in spite of this. Also, debridement was not done for 3 - 4 days. Cradles were improvised from barrel staves, etc. until others could be brought to the ship. All parts of the body including faces and hands were treated in like manner with tannic acid spray, the eyes being protected.

The experience seems to show that early debridement seems unnecessary, and also helps to prevent further shock. Fuel oil in the burns and wounds was a great problem, and seemed to aggravate shock. And these patients, when the oil was removed with green soap and water, seemed to recover quicker from the shock condition. It seemed necessary to remove the oil from the wounds to facilitate a good eschar forming. Other forms of treatment called for forced fluids, and these were given by mouth every hour, as it was impossible to set up enough intravenous apparatus for so many patients.

Cortical extract was not used. Although the speaker did not favor tannic acid for all types of burns, it seemed to be excellent treatment for 1st and 2nd degree burns with which they had most to contend. The good results seem to be due to early treatment. Sulphanilamide gms. 4 was given internally to all patients where infection or toxemia seemed to be present.

After the eschar was formed on the burns no further treatment seemed to be needed for 3 - 4 days, when the coagulum was removed as easily and gently as possible. This was followed by vaseline guaze, under sterile precautions, followed later by wet saline dressings.

Foreign bodies such as pieces of shrapnel, were let alone for several days. The wounds were packed with sulpha. powder and most did well. Early operation on two cases for removal of shrapnel proved fatal, and the speaker believed that this was due to shock.

In cases treated in the Naval Hospital in Honolulu where variety of treatment was used, the mortality and morbidity was higher than in his (Dr. Eckert's) cases, justifying the conclusion that early and adequate shock treatment counts most regardless of the type of burn treatment. The old dictum of certain amount of body surface being burned indicating the result of the case, did not seem to hold.

Summary of treatment:

1. Protect burn area.
2. Combat shock.
3. Relieve pain.
4. Minimize fluid loss.
5. Protect against infection.
6. 4 gms. sulfadiazine or
7. sulfanilimide orally.
8. Morphine gr. ½ doses.
9. Open or closed treatment for burns, although at Pearl Harbor, only closed treatment was used.

Dr. Eckert's paper was heartily received and brought forth many comments of the excellent treatment rendered by the Naval Doctors in this unexpected emergency.

The meeting adjourned at 10:10 P.M. A collation followed.

Alfred M. Tartaglino, M.D.
Secretary.

BEGINNINGS OF OCCUPATIONAL THERAPY AT RHODE ISLAND HOSPITAL

Miss Jessie Luther

Although the value of occupation in cases of mental disorders has been known and recorded from time to time during centuries, and has been applied as an organized form of treatment since 1904 at the Handcraft Shop (a small sanatorium) at Marblehead, Mass.; at Butler Hospital since 1906 and at about the same time at Bloomingdale Hospital, N. Y. and a few private sanatoria, all psychopathic institutions; such treatment had not been employed in other forms of disability until conditions among our overseas soldiers in the First World War gave impetus to the movement. We began to hear of restlessness and discouragement among convalescent patients in base hospitals behind the lines and the need of occupation to strengthen morale.

During the winter and early spring of 1918 tentative efforts were made to train classes in crafts with a view to possible overseas service, but these courses were too brief and inadequate to be very effective. Of more value were professional and amateur craftswomen, some of whom volunteered for service with the Red Cross and other units in France and did good work with, at first, little encouragement and less material help. At this time an effort was made at Washington, D. C. to establish an occupational therapy training school for craftswomen as volunteers for overseas service. Having been asked to assist in this school I waited until the plans, although definitely made, proved futile due to complications at Washington and then found a field for effort nearer home which proved to be Rhode Island Hospital.

Dr. John Peters, then superintendent, was in favor of occupational therapy but its application in general hospitals was, at that time unrecognized by many physicians who failed to appreciate its value in any but mental cases — and were sometimes skeptical in any case. One of the arguments against use of crafts as a treatment in any general hospital was a misconception of its purpose. The idea seemed to prevail that such training was intended to fit the patient for a new form of livelihood after his hospital discharge and the usually short period allowed for hospital residence would not allow time for adequate training and experience in a new type of work. The idea of the use of crafts or diversion as a mental and physical treatment aside from the economic or utilitarian aspect was not understood until later.

My work began in the spring of 1918 with two or three afternoon visits a week —, all I could spare from my regular duties as Occupational Therapy Director at Butler Hospital.

Owing to lack of hospital appropriations, materials were financed by the Social Service Department; I think as a special fund. Occupations consisted of simple crafts; basketry, (both reed and raffia); braiding rags for mats, knitting, and I think a little crochet. It was conducted mostly in Wards K and H.

The patients were men, women and boys, some in bed; some in chairs and several in small, self-propelled carts which they managed with remarkable dexterity. Men and boys made baskets and some braided mats, braiding was also done by some women. Knitting was done by women and one or two men had learned to knit scarves. The articles were helmets, sweaters, stockings and scarves for men overseas and sometimes there were gifts for friends or for personal use made from their own material by some of the women.

Accomplishment was limited owing to the patient's effort and ability as was to be expected, but everyone tried and I do not remember anyone who failed to show some intent and finally cooperation. I enjoyed my hours with them. For the most part the patients were short time cases— convalescents from different forms of disease, — post operative; accident cases, perhaps some cardiac, I do not now remember.

In August General Pershing visited the A.E.F. base hospitals in France; saw the 50% improved condition of wounded soldiers who were given occupation by the volunteer women and sent for 1000 trained aides. I enlisted for overseas Occupational Therapy Aide in Sepetmber and my work at Rhode Island Hospital came to an end.

Mrs. James W. Thornley, a craftswoman and associate of the Handicraft Club carried on the work with interest and efficiency until installation

of a definite Occupational Therapy Department with appropriate quarters and equipment made possible the fine development and effectiveness that we find at the hospital today. I am happy to have had a small part in preparing the way for this department and its development.

BOOK REVIEWS

Autonomic Regulations, Their Significance for Physiology, Psychology and Neuropsychiatry. By Ernst Gellhorn. Interscience Publishers, Inc. New York $5.50. December, 1942.

In this very readable book Dr. Gellhorn has undertaken to put together our knowledge of the function of the Autonomic Nervous System and the part that it plays in the activity of the organism as a whole.

Nearly a century and a half ago Bichat defined life as the sum of the forces that resist death. With the rise of general physiology, much of modern physiology has come to emphasize detailed investigations of the chemical and physical processes involved in cell function. But in recent years Cannon, in his books "Bodily Changes in Pain, Hunger, Fear and Rage" and "The Wisdom of the Body", has presented a modern view of the organism functioning as a whole, not unrelated to that of Bichat, which he has called *homeostasis* — the tendency of the organism to retain its original state, or to restore it when it is departed from.

It is from this point of view that Dr. Gellhorn's book is written. "The discovery of the principles by which the purposeful reaction of the organism is retained under stress and strain becomes the supreme task of an organismically oriented physiology, their application the problem of a scientifically oriented medicine and physiology."

The physician who has felt that the researches of modern physiology are only remotely connected with his problem of dealing with sick individuals will here find some of them oriented for his benefit. The more or less intangible characteristics of people, that serve as the basis of the "hunch" of the successful diagnostician, begin to have a scientific significance in this sort of physiology. Certainly here are clues to a scientific understanding of them.

The first two parts deal with the structure of the autonomic nervous system and the adjustment reactions in which the respiratory and circulatory systems are primarily involved. Part III deals with the integration of autonomic and endocrine activities, emphasizing their mutual interaction with a complete review of the pertinent literature. Similarly the mutual relation between the autonomic and somatic nervous systems is covered in Part IV. The discussion in Chapt. XIII of the carotid sinus reflexes admirably illustrates the organismic or integrative point of view. The suggestion, developed in Chapt. XVI, that the adjustment reactions which tend to restore the original conditions of the body are the result of an integration of autonomic and cerebrospinal processes is supported by an interesting and convincing selection of material. The last section deals with clinical results and applications, with a chapter on general and spinal anesthesia and one on the autonomic nervous system and neuropsychiatry in which there is a discussion of the mechanism of the action of agents used in the treatment of schizophrenia.

Each chapter concludes with a concise summary of its significant high points, and there is an exhaustive bibliography of 1100 titles. It is to be hoped that the general reader, whose physiology courses may be many years behind him, will not be frightened off by the many graphs and kymograph records throughout the book. These naturally give to the reader who is habituated to their use, a vivid presentation of a great deal of detail that would be presented otherwise only with difficulty. They are necessary to give weight to the discussion particularly for those who might view it critically or sceptically. The general reader may well take their contents for granted and should find no difficulty in understanding the context they are supposed to support.

J. Walter Wilson, Ph.D.

The Anatomy of the Nervous System. By S. W. Ranson. Seventh Edition, revised. W. B. Saunders Company. 1943.

A new edition of this standard textbook of neurology hardly needs a review addressed to a profession which must be thoroughly familiar with

the previous editions. To anyone having a use for a knowledge of neurology it has for many years been indispensable. In each new edition Dr. Ranson has collected all the important new advances in this subject, and, with the reliable judgment of one of the most active investigators in his field, he has oriented them in the body of established knowledge. In this edition more physiology has been added and there has been an extensive revision of the sections on the cerebellum, thalamus, hypothalamus, cerebral cortex, and sympathetic nervous system. The superb book work characteristic of many of the Saunders texts, with the fine reproduction of the numerous figures, many of them in color, makes it a very attractive volume.

It is to be regretted that owing to his recent death this will be the last revision by Dr. Ranson. The publishers announce however that future revision will be in the hands of Dr. Sam L. Clark of Vanderbilt University School of Medicine, so that its successful continuance in the future seems assured.

J. Walter Wilson, Ph.D.

Doctors of the Mind by Marie Beynon Ray. Little, Brown & Co., Publishers.

This is a book written for the general reader and not particularly for the physician or the psychiatrist. The author, who is an experienced writer, has made an exhaustive study of the history of man's development, starting with "Degenerate Adam or Perfected Ape" and discussing the advances and progress in the study and treatment of diseases of the nerves, and then of mental diseases, up to occurrences within the past six months. It is carefully written and in interesting language. At times, as one would expect, the point of view is quite different from that of the man trained in medicine. Again the greater attention appears to be given to the more dramatic aspects of treatment, and some of the newer aspects of physical measures, such as shock therapy of various types, are more emphasized than various measures in what is strictly psychotherapy. The physician will find this work easy, interesting reading and, although written in popular language, it will bring him up to date on the latest advances in psychiatric treatment.

Niles Westcott

The Mask of Sanity by Hervey Cleckley, B.S., B.A. (Oxon.), M.D. Professor of Neuropsychiatry, University of Georgia School of Medicine, Augusta, Georgia. C. V. Mosby Co., Publishers.

There is a border line between the fields of the psychiatrist and the legal profession which may be said to be inhabited by those who are problems for both, sometimes called the "Constitutional Psychopath" or the "Psychopathic Personality" or the "Contstitutional Psychopathic Inferiority". In this book of about three hundred pages Dr. Cleckley makes a masterful attack on the presentation of the subject. He has had unusual preparation for a study of the subject. He is a teacher of medicine, has been connected with a large neuropsychiatric hospital, and has contact with more than his share of patients who have been under the care of various organizations such as those in charge of veterans of the former World War. This work gives an outline of the problem, stressing the prevalence of the disorders, the clinical picture presented, even when the patient is scientist, physician, or psychiatrist, and there is a careful distinction from other personality disorders; in other words, careful differential diagnosis. There are copious case histories, and finally an attempt is made to interpret the situation as to what is wrong, how such a change occurred, and finally "what can be done about it". While the questions are not fully answered, this is a splendid presentation of the subject and it should be stimulating to the psychiatrist and the man interested in legal medicine.

Niles Westcott

Mental Illness: A Guide for the Family by Edith M. Stern with collaboration of Samuel W. Hamilton, M.D. Commonwealth Fund, Publishers.

This is a carefully prepared manual for those who are in contact with mental illness through relatives or friends who have become hospital patients. It is written by one Edith M. Stern, who has had experience in the preparation of subjects for those who are outside the medical profession. Dr. Hamilton, who following a long hospital experience, has also been an officer of the National Mental Hygiene

Society, and is acting in an advisory capacity with the United States Public Health Service, has been able to advise and direct the material presented in this handbook. It is a masterpiece in its simplicity; —practical, understandable, and helpful. The writer touches on important legal points and many technical points which, if heeded, would make the hospitalization easier for everyone concerned. Dr. Hamilton stresses in his preface the need for a manual of this kind. For, no matter how carefully the admitting officer in a hospital may try to enlighten the relatives of the incoming patient, the actual time of admission is not the time to burden them with hospital rules and regulations. In a few words, this book, bridging the ground as it does between the patient in the hospital and the relatives on the outside, is a concise, well written, volume, fitted for a place, not only in the library of those who have relatives in the hospital, but also in the physician's office, as an aid to relatives of those who need to become in-patients.

NILES WESTCOTT

TEXTBOOK OF CLINICAL NEUROLOGY. By Israel S. Wechsler, M. D., W. B. Saunders Company.

For approximately fifteen years now and through the medium of four previous editions, Dr. Wechsler's "Textbook of Neurology" has been one of the standard and good books on the subject of clinical neurology. His latest and fifth edition possesses the same good qualities as its predecessors. It presents the subject material in a manner that is concise and based mainly on the author's personal teachings and clinical experience. The passage of four years since the publication of the last edition has witnessed a sufficient number of advances in neurology to justify this new and revised edition. In it one finds that recent advances have been well incorporated and as a modern textbook on clinical neurology this book is therefore well recommended.

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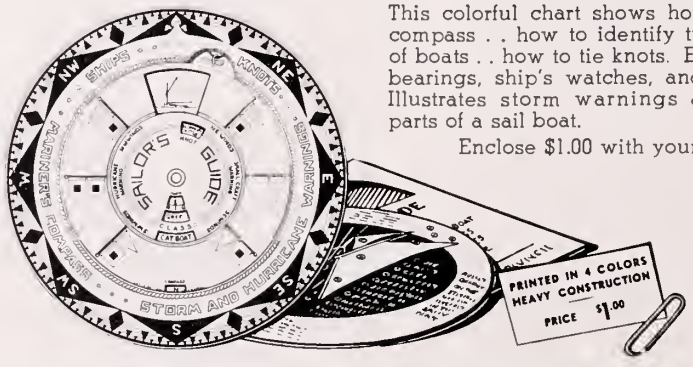


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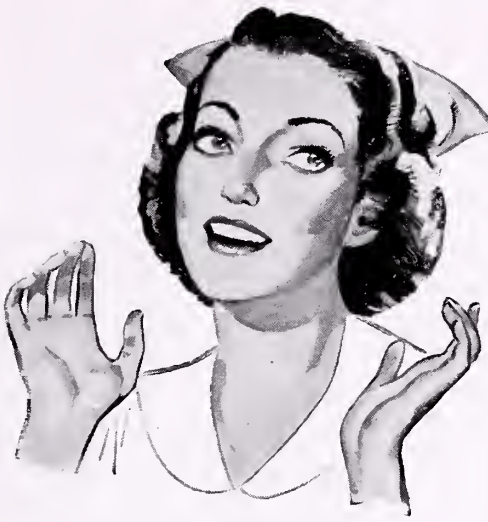
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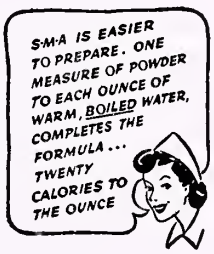
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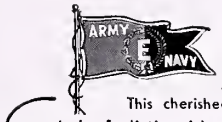
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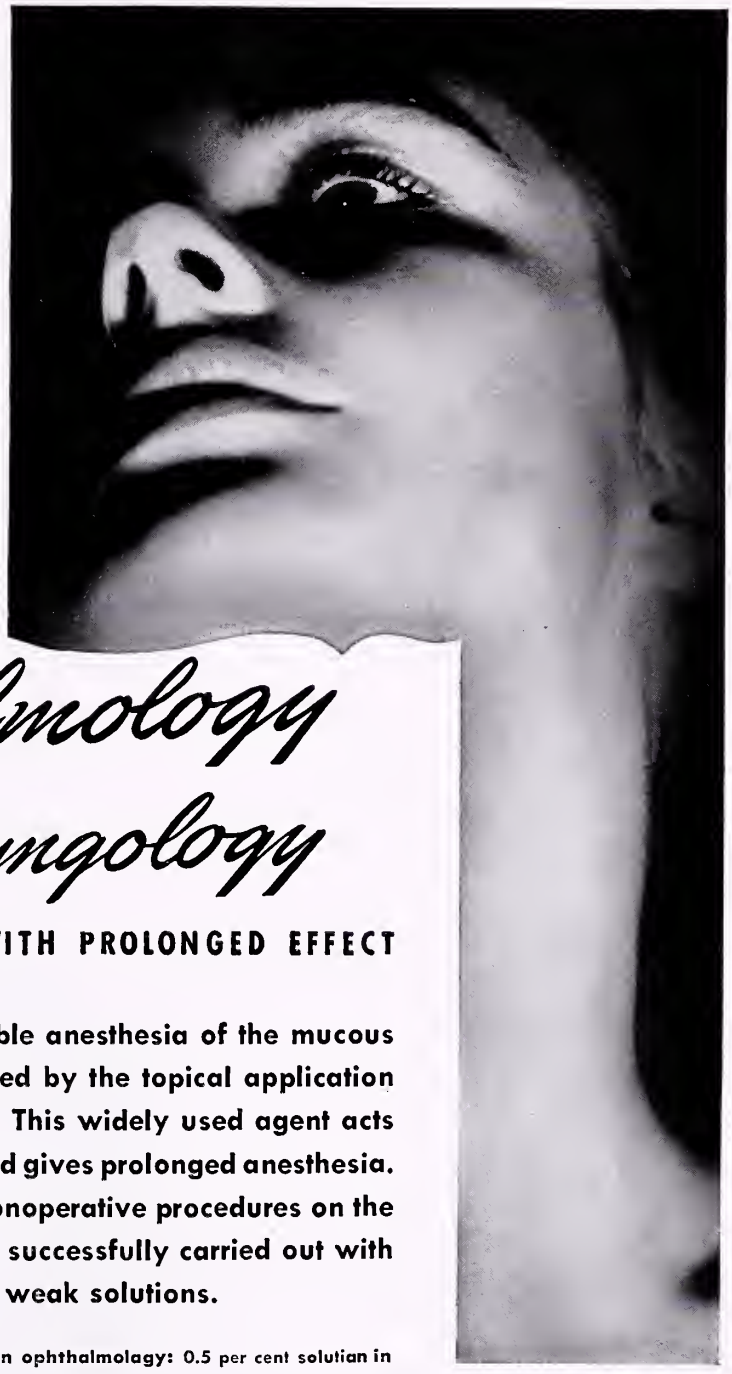
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Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60



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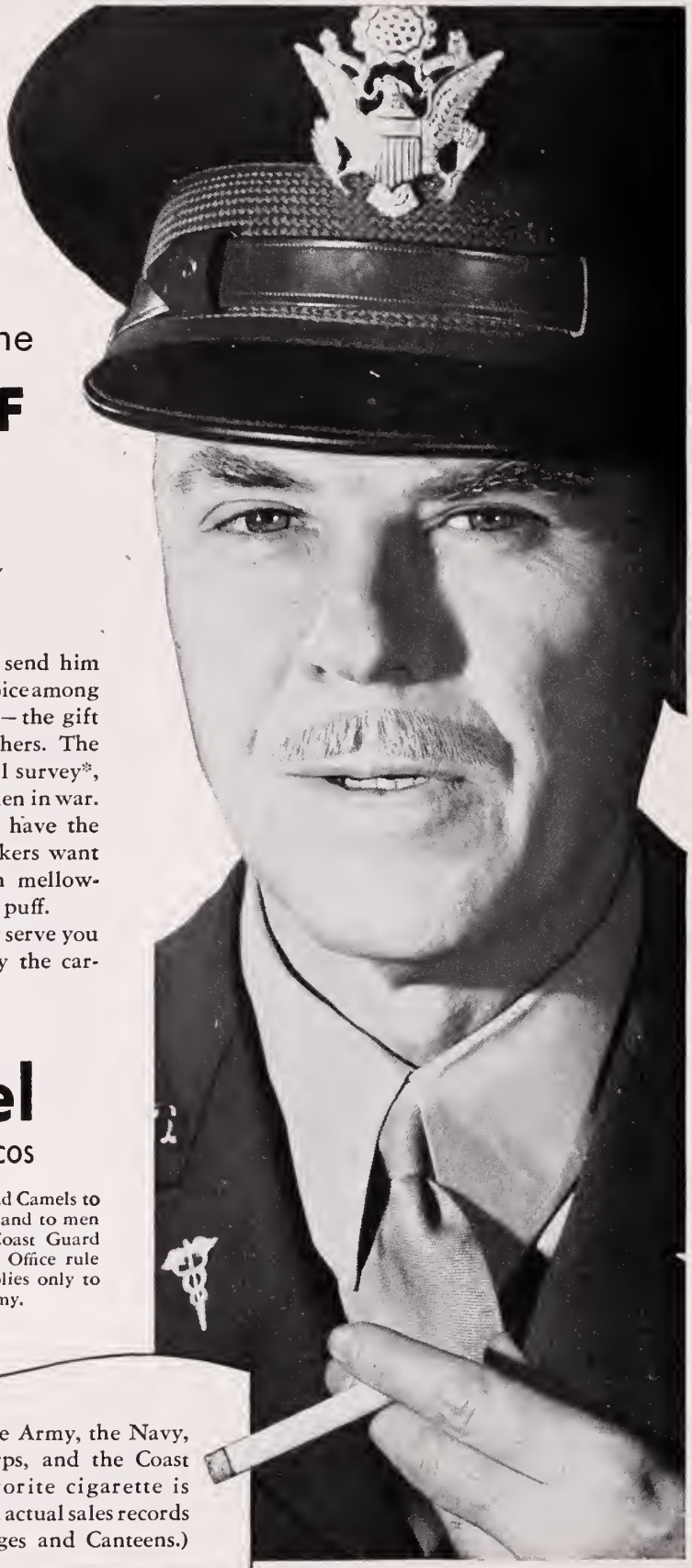
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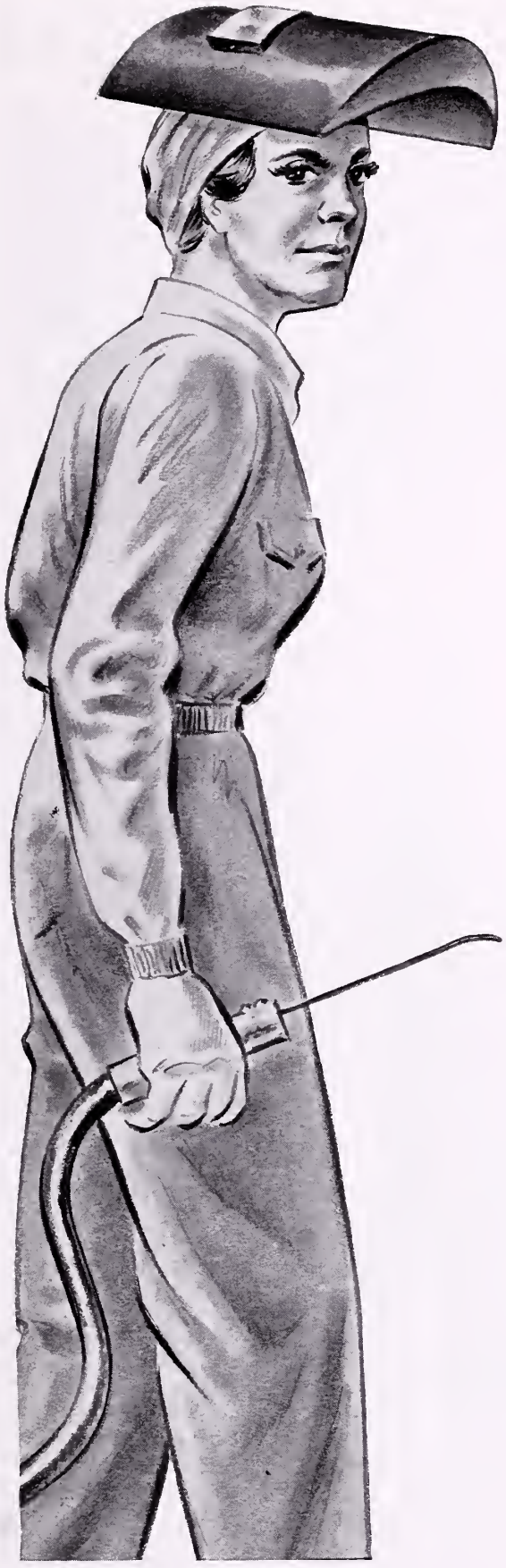
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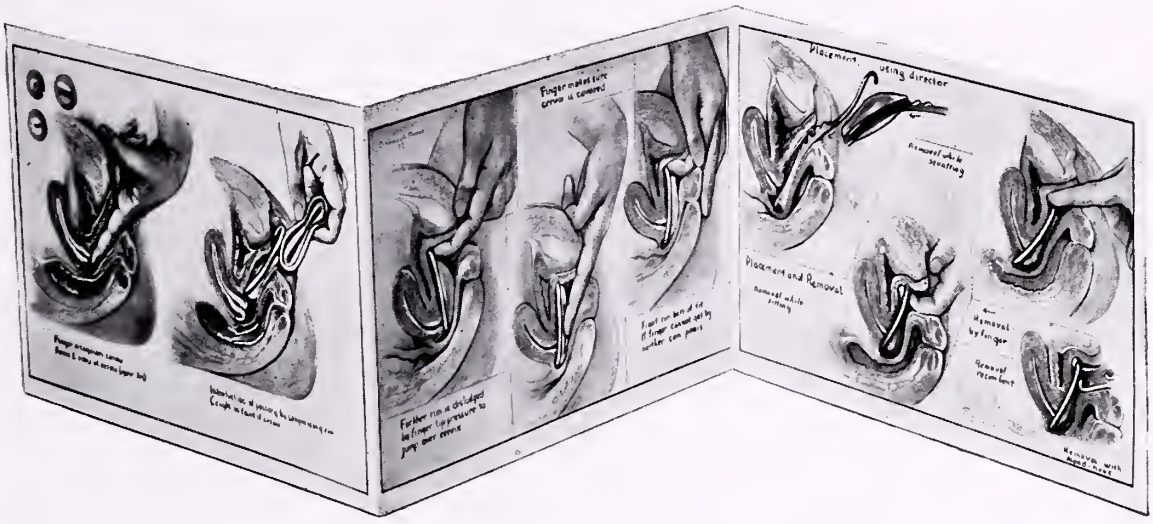
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THE RHODE ISLAND MEDICAL JOURNAL

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BLEEDING IN THE HEAD FOLLOWING INJURY

Some unusual examples

WILFRED PICKLES, M.D.

One of the most serious complications of head injuries is the occurrence of bleeding within the head. When this bleeding is diffuse there is little that can be done for the patient except to treat the associated brain damage; but when the hemorrhage is localized surgical treatment may be of great value. Injury of the middle meningeal artery may result in local bleeding within the skull but outside the dura, and the consequent pressure may give a clearly recognizable picture of extra-dura hemorrhage. Injury of the bridging veins may cause a local collection of blood under the dura but outside the arachnoid; when such a collection occurs rapidly it may present a clinical picture very closely resembling extradural hemorrhage; when it occurs more slowly, it may be hard to recognize and its presence may only be shown by exploration; in either case, surgical drainage is of value. These are the usual types of local bleeding.

In this communication I should like to report three unusual instances of bleeding in the head following injury. In two of the patients, the hemorrhage was localized beneath the pia but outside the cortex. In the third, bleeding under the cortex gave rise to signs and symptoms closely imitating those found with extradural hemorrhage.

I. *Subpial Hematoma*

At about 2:30 on the morning of Sunday, April 19th, 1942, a fifty-one year old Italian cement finisher, L. C., (R. I. Hospital No. 355725), fell backwards down a whole flight of stairs at his home. He had been a heavy drinker for many years, and was drunk at the time of the fall. When members of his family reached him, he was unconscious and he remained so for five or ten minutes. He then roused a little and was put to bed where he stayed, restless and swearing occasionally, for the rest of the night. At 7:45 he called out that he could not move his right arm and leg. Throughout the day his condition remained about the same; he spoke only a few times, complaining of severe headache, and vomited twice. On the morning of the twentieth he was still unable to move his right arm and leg; he was restless, spoke only infrequently, and answered, "Shut up", to any questioning. He was then attended by his own doctor, who sent him to the Rhode Island Hospital for treatment.

I first saw him soon after his admission to the hospital. His past history was incomplete, the only important items being a story of a fractured leg and pelvis fourteen years before the present accident, and a statement that he had had a high blood pressure for many years. His rectal temperature was 100.4, his pulse 120, and his respirations 22. He appeared somewhat older than his fifty-one years, and was lying in bed restlessly moving his left arm and leg almost constantly; his right arm and leg did not move. Any attempt at restraining the movements of the left extremities was resisted vigorously. He did not speak coherently or answer questions, but mumbled an occasional oath and yawned a little. His head was turned to the right, and he seemed to follow objects with his eyes. His breathing was easy and regular, his color was good, and

Presented at a Meeting of the Providence Medical Association, April 5, 1943. From the Neurosurgical Division of the Surgical Service, Rhode Island Hospital.

his blood pressure was 180/118. There was no external wound of the head, but in the right parietal region near the occiput a slight linear depression could be felt through the scalp. The pupils were of average size, equal, regular, and reacted to light; the eye movements were not remarkable; and no diagnostic view of the fundi was obtained. There was no bleeding or other discharge from the ears, nose, or mouth, and there was no stiffness of the neck. The heart, lungs, and abdomen seemed normal. When the right elbow was moved there was a slight snapping sensation, and there was a small abrasion on the left elbow. Tendon reflexes in the right arm were more active than in the left; in the legs, they were moderately active and equal on the two sides. The abdominal reflexes were absent. There were no Hoffman or Babinski responses, and there was no ankle clonus.

Basing our opinion on the story and examination, we felt that this man might have an extradural hemorrhage, although this seemed unlikely; that he probably had a subdural hematoma; but that the possibility of a primary cerebral hemorrhage causing the fall could not be ruled out. The visiting neurologist, Dr. Jerome J. McCaffrey, saw the man in consultation and, feeling that the evidence was consistent with the presence of a subdural hematoma, advised operation.

An anterior transtemporal incision was made on the left side. The temporal muscle was found to be contused and had clotted blood scattered through its fibres. It was divided and the underlying bone exposed; no fracture line appeared in the veld. The bone was penetrated with Hudson drills and the opening was enlarged with rongeurs; the skull was quite thin. There was no extradural bleeding. The dura was rough and irregular; vessels on its surface were tied off with silk stitches; it was then opened between traction sutures and was found to be much thicker than usual. This opening of the dura freed a large fluid subdural hematoma containing a mixture of blood and cerebrospinal fluid, the drainage of which left a cavity about three inches in diameter and three quarters of an inch deep. At the bottom of this cortical depression, and directly under the opening in the bone and dura, was a bluish-gray mass crossed by dilated pial veins and covered with a thin, translucent membrane. Anterior to this mass, which was roughly circular and had a well defined border, the cortex appeared to be grossly normal; posteriorly, the edge was hidden under the dura. With careful avoidance of injury to the dilated veins, the membrane was incised and the mass was found to be made up of clotted blood and some old fluid blood. The opening through the pia was enlarged and the fluid part of the hematoma was allowed to drain off. As the clot was intimately applied to the underlying cortex, it was considered unwise to attempt its complete removal, for fear of causing greater damage to the cortex. The pial opening was therefore left to permit later extrusion or drainage of broken down clot. A rubber tissue drain was placed down to the region of the subpial hemorrhage, and the wound was closed in layers about the drain with the usual interrupted silk stitches. During the operation the patient was given 5% glucose in saline by vein and this was followed by 500 cc. of blood. At the close of the operation he was in fairly good condition.

On the next day, the restless movements of the left arm and leg continued; the right arm and leg remained still except for occasional clonic involuntary movements; the head and eyes were turned to the right, and there was a left facial tic. He was in deep coma, and vomited twice. Lumbar puncture showed an initial pressure of 420 mm. of blood tinged fluid; 10 cc. were taken off and found to contain red cells and a total protein of 154 mg.; the final pressure was 220 mm. He was given oxygen by nasal catheter and 10% glucose in saline by vein. At first there was moderate drainage of blood stained fluid from the wound; this soon stopped, and the drain was removed on the third day. As he was incontinent, he was put on tidal drainage. The convulsive movements gradually subsided and he seemed to be slowly improving and coming closer to the surface of consciousness. Repeated lumbar punctures showed a steady decrease in pressure and protein content, the final observation showing an initial pressure of 225 and a protein of 35. On the sixth day, however, he developed signs of pneumonia in the left lower lobe; he was given sulphadiazene and another transfusion, but on the seventh day he died.

Postmortem examination by Dr. Ralph Brown showed that there were multiple fractures of the skull starting at the vertex and passing down on both sides to parietal, frontal and occipital regions.

On the right side of the head there was a thin, widespread extradural hemorrhage; a dural laceration; and a thin subdural hemorrhage. On the left side, the subdural hematoma had been drained away, and the subpial clot had largely disappeared but there remained evidence of some subpial hemorrhage. The convolutions appeared normal, but there were numerous petchial hemorrhages in the cortex. There was no gross evidence of cerebral hemorrhage.

Here, then, for the first time in our experience, we met with and recognized a localized hematoma beneath the pia. In this patient the lesion was associated with much other damage within the head and it is not surprising that the man died. The postmortem findings showed, however, that the clot had largely disappeared in the course of a week, and led us to hope that surgical drainage of such a condition might be successful in a patient with less extensive associated injuries.

II. *Subpial Hematoma*

M. R. (R. I. Hospital No. 359033), a thirty-five year old jewelry worker, was struck by a street car at about ten-thirty on the evening of July 25th, 1942. He became unconscious at once and was sent to the Rhode Island Hospital by ambulance directly from the scene of the accident. On his arrival at the hospital, he was in moderate shock and did not respond to questioning or painful stimuli. There was bleeding from a laceration of the upper lip, and there was some blood in the nostrils. The left parieto-occiptal region was somewhat flattened, there was considerable bitemporal swelling, and there was beginning ecchymosis behind each ear. The eyes were deviated to the left, without nystagmus; the pupils and fundi were normal. The reflexes were normal except for bilateral Babinski responses, the right one being somewhat more marked than the left. Under shock treatment, his condition gradually improved, and he passed from coma into a state of considerable excitement. Lumbar puncture showed blood tinged fluid under an initial pressure of 400 mm, containing red cells and 86 mg. of protein. At first there was some weakness of the right arm, but this cleared up; later there was disability of the left elbow, apparently due to local injury. He ran a moderate fever and was treated in the usual way, with fluids, sedation, and repeated punctures. At the end of two weeks his spinal fluid findings as to pressure, protein and cell count were normal, but he was still confused, overactive, and incontinent of urine. X-rays showed multiple fractures in both parietal and occiptal bones, separation of the lambdoid suture, and some flattening of the skull posteriorly, particularly on the left. Dr. Ernest A. Burrows, the visiting neurologist, saw him in consultation and felt that the man's condition was more likely due to diffuse brain damage than to local pressure.

For the next two weeks, the patient's condition remained about the same, except for occasional rises of temperature for which no good cause could be found. On September second, he was seen again by Dr. Burrows who found that he had bilateral ankle clonus and increase of tone in the left lower extremity, and recommended exploration for a possible right subdural hematoma. This was done on September 12th.

The usual right transtemporal incision was made and carried down through the muscle to the bone. The periosteum was reflected and the skull entered through a drill hole enlarged with rongeurs. Overlying the dura there was evident a very thin layer of partly organized extradural blood. The dura was found to be thickened and moderately tense, but not bulging. Traction stitches were inserted and the dura was opened between them; this released a moderate sized fluid subdural hematoma containing old clots and clear yellow fluid. When this had been allowed to drain off, the underlying brain presented a very curious appearance. The upper posterior part of the visible brain seemed normal; in the lower and anterior two-thirds, however, the pia was edematous and tense, transmitting a bluish appearance, with no convolutions visible through it. An incision was carefully made through the pia and this freed a second collection of clear yellow fluid and old clots. About two ounces of fluid was removed, and it was then possible to see moderately injected brain tissue through the pia. The entire extent of the hematoma could not be made out but it was felt unwise to expose it further, as drainage was felt to be sufficient treatment. A small rubber tissue drain was placed down to the pial opening, and the wound was closed about it in layers with interrupted silk stitches.

The man made a good operative recovery. He regained control of urine and became mentally

clearer and much quieter almost at once. There was moderate drainage of blood stained cerebrospinal fluid for three days; the drain was then removed, and the wound healed promptly without further drainage. From then on, he made a very slow but steady improvement. The bilateral ankle clonus disappeared, his ability in carrying on a conversation increased, his memory improved, and he began to walk after a period of re-education. On January 5th, Dr. Burrows found him generally improved, with some ataxia of upper and lower extremities; the right pupil was somewhat larger than the left; he walked guardedly and talked much better than at any previous time; his mind, recent memory and mood appeared to be good at that time. He was discharged on February second with the improvement continuing slowly.

This was our second meeting with a localized collection of blood between the pia and the cortex; in this instance, our hope of improvement by surgical drainage was borne out.

III. *Subcortical Hematoma Simulating Extradural Hemorrhage*

On the morning of September 19th, 1942, V. W. (R. I. Hospital No. 360974), a fifty-five year old mill worker, slipped while climbing a ladder and fell head first for about ten feet onto a concrete floor. He did not lose consciousness and when he was picked up said that he felt all right. He remained at work for several hours, but must have felt some ill effect as he decided to leave work and see a doctor. He went to his home and, after taking a shower, called at his doctor's office. Examination at about two o'clock showed an abrasion in the right fronto-parietal region with no evidence of more serious damage. A dressing was placed on the abrasion, and the man then boarded a bus to go down town to buy a suit of clothes. When the bus reached the center of the city, the man sat motionless and was unable to leave his seat or to speak; his head and eyes were turned sharply to the right. An ambulance was called, and the ambulance surgeon made the following note:

> "The right hand and right leg could move, but not the trunk. En route to the Rhode Island Hospital I conversed with him. He understood what I said, because when I asked him to squeeze my proffered right hand, he did so with his right. He could not move his eyes or say anything and constantly strove to alter his position as if he must get up and go some place, and in this respect seemed confused, since my advice to lie quiet had no effect. His pupillary reflexes seemed good."

He was admitted to the Hospital at about 3:30 o'clock, when his temperature was 99.6 and his pulse 65. His blood pressure was 185/140. It was then learned that eighteen years before this admission he had had a shock with hemiplegia, from which he had made an almost complete recovery.

Soon after his entrance to the Hospital the man became unconscious and vomited several hundred c. c. of unstained stomach content. The visiting neurologist, Dr. Jerome J. McCaffrey, was called and made the following note:

> "6 P. M. Patient is unconscious. Left arm and leg are flaccid. Neck not stiff. No Kernig sign. Right pupil larger than left. Pupils appear fixed to light. He has conjugate deviation of eyes to the right. Right fundus well visualized and optic disc is well outlined but pale, and retinal arteries are sclerotic. Left fundus not seen. No tendon reflexes obtained on left; on right they are about 2 plus. Bilateral Babinski. No ankle clonus. He has a hematoma in right fronto-parietal region. History of head injury at 11 A. M. without loss of consciousness and of loss of consciousness at 3:30 P. M., following which he had a left hemiplegia."

Dr. McCaffrey felt that the man had either an extradural hemorrhage or an acute subdural hematoma and asked me to see the patient with him. I agreed with him as to the findings and diagnosis, and accepted him for immediate operation.

A right subtemporal exploration was done. The usual incision was made and carried down to the bone, which showed no evidence of fracture. A burr hole was made with the Hudson drill and enlarged slightly with rongeurs. No extradural bleeding was found. As there was a bluish discoloration under the dura it was felt that we might be dealing with an acute subdural hemorrhage simulating an extradural, so the dura was opened. No subdural hemorrhage was found, the bluish discoloration being due to dilated veins. In spite of the smallness of the opening, the brain showed a distinct tendency to herniate, so fifty c. c. of 50% sucrose was given

by vein without remarkable result. A lumbar puncture was accordingly done and this showed blood tinged fluid under a pressure of 400 mm. The pressure was reduced to 160 mm. and this relieved the herniation enough to allow closure of the wound without damage to the cortex.

As would be expected, there was no improvement in the man's condition following operation. He remained unconscious; the left arm and leg stayed motionless except for occasional convulsive twitchings; and he became incontinent of urine. His temperature rose to 104, his pulse to 90, and his breathing became labored, rapid and irregular. He died at 2:20 the following morning. Our clinical diagnosis was contusion of the brain.

A post-mortem examinaation was made by Dr. Harold Williams. It showed arteriosclerosis of the aorta, coronary arteries and cerebral arteries; arteriolar nephrosclerosis on the right, hypertrophy of the heart; chronic passive hyperemia of the liver; hyperplasia of the prostate; bronchopneumonia; and acute splenitis. The examination of the head was naturally of the greatest interest and was as follows:

"The scalp is opened by extending the surgical incision upward and around to behind the left ear. When the scalp is reflected there is found to be no hemorrhage into the scalp beneath the abrasion in the frontal area. There is found to be a portion of bone removed at the surgical incision. The brain tissue bulges out slightly through this defect. The calvarium is removed in the usual way without difficulty. There is no hemorrhage either outside or beneath the dura. The dura is stripped away and the entire skull carefully examined for fractures. None are found. The brain weighs 1325 grams. The vessels at the base are moderately sclerotic. There is a small amount of clotted blood about the base of the brain. In the left frontal region, there is a cystic area about 4 cm. in diameter. It has a smooth lining and contains a yellowish fluid. There is brown blood pigment in its wall. (Evidence of the cerebral hemorrhage from which he had recovered eighteen years before.) The central part of the right hemisphere bulges and on palpation is firmer than elsewhere. On section there is found to be a large area of hemorrhage. This is found to begin about 5 cm. posterior to the frontal pole. It destroys a large part of the parietal lobe and extends into the temporal lobe. It is about 10 cm. in its anteroposterior diameter. At the midpoint there is only about 4 mm. of cortex over it. It has broken into the right lateral ventricle. This ventricle is filled with blood. The blood also fills the third and fourth ventricles and, as was mentioned above, has escaped about the base of the brain."

Here, then, we have a man with a train of symptoms and signs strongly suggesting pressure on the right motor cortex. Basing our judgment on our experience up to the time of seeing this patient, we felt that he had either an extradural hemorrhage or an acute subdural hematoma. In this instance, however, the bleeding and consequent pressure were beneath the cortex and the true state of affairs was not found at operation. The possibility of the surgical relief of this condition should be seriously considered; the insertion of a ventricle puncture needle might drain off sufficent blood to permit recovery, or the making of a small opening through the cortex might allow the extrusion of clot already formed. If we are faced with a similar combination of findings in the future, we feel that an attempt at drainage of a subcortical hematoma will be justified.

184 Waterman Street

PROCUREMENT AND ASSIGNMENT

The Chairman of the Rhode Island Committee for Procurement and Assignment of Physicians, Dr. Halsey DeWolf, 305 Brook Street, Providence, asks that all those medical men in the State who are entering the military services, notify him by phone or by mail the details of such service. This is most important information and very difficult to obtain, other than through the individual in question. Dr. DeWolf will appreciate any communication on this subject.

CLINICAL PATHOLOGICAL CONFERENCE

Case Presented by Alex M. Burgess, M.D. at March Meeting of Providence Medical Association.

Sixty-one-year-old married machine tool company inspector entered the R. I. Hospital January 28, 1943 because of increasing weakness of three months' duration and the passage of black stools.

Present Illness: During the past three months he had noted this increasing weakness and from time to time, a black or dark-colored stool. There had been occasional pain in the lower abdomen, usually after eating. He had not vomited.

During the year previous to his admission, he states that his bowel activity had become regular, whereas formerly he had been frequently constipated.

No history of jaundice, hemoptysis or syncope. No recognized loss of weight.

Three months ago, the patient also had what he called "bronchitis" associated with repeated attacks of substernal pain related to respiration and causing some dyspnea.

Past History: No previous illness admitted. Right foot was injured in a railroad accident 35 years ago and patient was admitted to a hospital at that time.

He has worked as a machine tool inspector for five months. No history of any industrial hazard.

No statement as to habits.

Family History: Not recorded.

Physical Examination: Blood pressure 105/65. *General:* A well-developed and nourished man who appears very pale and weak. *Head:* Not remarkable. *Eyes:* Conjunctive pale. Sclerae clear. Pupils normal. *Nose:* Unobstructed. *Mouth:* Mucosa pale. Breath foul. *Neck:* Supple. No masses. *Chest:* Clear to percussion and auscultation. Heart rate and rhythm normal. Sounds very distant. *Abdomen:* Relaxed and flat. No masses or tender areas. There is a vague area of increased density in the midline of the lower quadrants. *Genitalia:* Normal male. *Rectum:* Sphincter tone good. Prostate enlarged—chiefly left lateral lobe. Hard and not tender. No hemorrhoids. *Extremities:* Mineral pitting edema.

Neurological: In order.

Course in Hospital: On the morning of the day after admission, the patient had a "sudden feeling of substernal oppression and dyspnea" which he said felt like bronchitis.

At 8 P. M., on the same day, a cardiac arrythmia was noted with "1:3 dropped beats."

On the third hospital day he was described as "much weaker" and his anemia was said to be more profound, and his blood pressure low. His pulse was described as "slow and faint." He was given 1500 c. c. of whole blood without noticeable improvement.

At 11 P. M. that night, it is noted that his pulse was not palpable at the right wrist and was faint at the left. His extremities were warm and dry, his respirations deep and he responded well when spoken to.

On the fourth hospital day, the note states that the patient had complained, during and after each transfusion, of "terrible pains either in his chest or lower abdomen, or both." In the course of one transfusion, it was noted that the pain was relieved "immediately after shutting off the blood flow." This pain had occurred despite the fact that the patient had had sodium phenobarbital and morphine before the transfusion. There were no signs of an anaphylactic or an allergic reaction to the transfusion. In all, the patient received 2,000 c. c. of whole blood by transfusion on the third and fourth hospital days.

The patient died at 4:40 A. M. on the sixth hospital day. The nurses' notes suggest that he had been dyspneic at times and apprehensive at times, but that at other times he had "enjoyed visitors."

Of the many blood pressure readings recorded, only the initial one was above 100 millimeters of Hg., in fact all subsequent readings showed a systolic pressure below 90.

Laboratory Work: Chest X-ray: Examination of the chest shows generalized accentuation of the lung markings particularly at the right base in the region of the cardiohepatic angle which may be due to an early infectious process. There was no evidence of pneumonitis in other portions of the lungs, or fluid in the pleural cavities. The heart shadow is considerably larger than normal, particularly in its tranverse percussive diameter. The great vessels are within normal limits and there is no fluid in the pleural cavities.

Electrocardiogram: The tracing shows a sinus trachycardia. Rate 118. Conduction time is within normal limits. ST-I is depressed with a diphasic T-1. ST-II is also depressed with an inverted T-II. ST-III is slightly elevated with an inverted T wave.

In the fourth lead there is a small initial deflection with upright T wave.

The voltage is low throughout. Left axis deviation is present. The tracing does not show a typical electrocardiographic pattern of an acute coronary but there are changes in the tracing that are suspicious of such an event. A tracing in a few days might be very helpful in this case.

Urinalysis: Color—amber. Reaction—acid. Sp. Gr.—1.016 and 1.015. Sugar negative. Albumen negative. Sediment — slight amount. Casts — loaded with hyaline. White blood cells—2 and occasional. Red blood cells—none.

Blood: Hemoglobin 7.1 and 9.8 Red cells—2.02 and 2.72.

Summary:

The main facts in this 61-year-old man, are as follows:

1. Three months' weakness and tarry stools.
2. Repeated attacks of abdominal pain and substernal oppression and dyspnea—in hospital associated with arrythmia.
3. Enlarged heart by x-ray.
4. Low voltage and T-wave changes in electrocardiogram, which suggest myocardial damage. Low blood pressure on all records.
5. No bowel movement or stool examination recorded.
6. Marked anemia, only slightly improved by 2,000 c. c. of whole blood.
7. Restlessness, disorientation, dyspnea, falling blood pressure, ashen pallor and death.

DISCUSSION

The problem resolves itself into two phases.

1. Gastro-intestinal.
2. Circulatory.

1. In relation to the digestive tract we have the history of tarry stools as the only really important fact on which to base an opinion. Low abdominal pain, weakness and a change in bowel habits is also mentioned.

There is also the fact of a well marked anemia. This, if related to the gastro-intestinal lesion as we may suppose it is, suggests either advanced malignancy or considerable blood loss. The absence of recognized weight loss favors the latter. Except for the "vague area of increased density" in the abdominal examination we have no further evidence on which to base a judgment. As there was no real recuperation or improvement following the administration of 2000 cc. of whole blood one must assume that the bleeding continued. The record reveals no evidence that the patient had a bowel movement during his hospital stay.

We may therefore say that this man probably had a bleeding lesion of the gastro-intestinal tract. There is nothing whatever on which to form a judgment as to what such a lesion might be. Peptic ulcer and an ulcerated carcinoma should be considered.

2. As to the circulatory system we have much more on which to base an opinion. The attacks of oppression and dyspnoea, the enlarged cardiac shadow and the electrocardiographic changes are all suggestive of myocardial infarction in a heart which has previously been enlarged. This enlargement, as no murmurs were noted, was probably due to previously existing hypertensive or arteriosclerotic heart disease. The continually low blood pressure readings are in accord with this view.

In the final death of this individual both of the above factors probably played a part. The final picture with restlessness, dyspnoea, falling blood pressure and ashen pallor makes me feel that continued hemorrhage was an important factor.

At post-mortem I would expect to find a large heart with a recent myocardial infarction and an ulceration in the gastro-intestinal tract, probably in duodenum, stomach or large bowel. The presence of black stools rather than fresh blood in the history would favor the first two of these. In the lumen of the intestine I would expect to find an amount of blood at least equal to the two litres which he received.

DR. CLARKE'S DISCUSSION

The entire intestinal tract was filled with black tarry stool (blood). Just distal to the pyloric valve on the posterior aspect of the duodenum was a deep, punched out ulcer about 1 cm. in diameter. In its base five small arteries were exposed.

There was marked sclerosis of the coronary arteries with narrowing of the lumen. At a point about 1 cm. below the bifurcation of the anterior coronary artery the descending branch was occluded by recent thrombus. A large portion of the interventricular septum and of the anterior wall of the left ventricle was infarcted and necrotic. (Pictures shown.)

Microscopic study shows changes thought to indicate a duration of about five days.

DIAGNOSIS: Duodenal ulcer with hemorrhage. Myocardial infarction.



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REDISCOVERING THE OLD

As the surgeon was suturing a wound with the familiar near, far, far, near stitch used to take tension on the skin from a distance and yet to bring the edges accurately together the intern said, "Oh, that is the Jones stitch" or the Schickelgruber or whatever was the name under which it had been brought to his attention. As a matter of fact a historically minded confrere had shown that this stitch had been invented or discovered many times, each succeeding surgeon proudly attaching his name to it.

Bohler, the famous Viennese treater of fractures, opens his book by demonstrating that there is about four and one-half inches difference in the length of the gastrocnemius accordingly as it is at full stretch or completely relaxed. As it is muscular pull that causes a shortening of the leg when fractured, it is easily seen that a position of partial relaxation of both extensors and flexors is the ideal. Bohler credits Zuppinger with this demonstration. But in the age of Samuel Johnson and the American Revolution Percival Potts demonstrated this. Probably Hippocrates did also.

Over thirty-five years ago Charles Harrington, Professor of Hygiene at Harvard Medical School, said that soap and water was the best antiseptic. For most of that time Tincture of Iodine and other strong irritants have been the materials of choice in and around wounds on that principle that if you hit a fly on your baby's head with a baseball bat you will kill the fly, which is desirable. Now we find that surgeons have come back to soap and water. Probably some one has attached his name recently to this procedure.

War surgery has brought into prominence the Orr treatment, applied mostly to compound fractures. There are several details of value but in general the idea is to afford rest to the injured parts. Physiological rest is promoted first by removing the dead or vitally injured tissues, drainage provided, and then a plaster cast applied, stopping all movement and prohibiting enthusiastic surgeons from doing daily dressings. It was no uncommon thing in the last war for men to be chloroformed at frequent intervals that their great dressings might be wrenched away from the granulating tissue clinging to them and a neat set of fresh draperies applied. Gwathney invented his cocktail of olive oil and ether for this purpose.

Now the value of rest has been appreciated from the time of Hippocrates but the classic work on this is James Hilton's Rest and Pain published eighty years ago. Hilton's thesis is just this. Remove offending agents, get the maximum situation for relaxation to the injured organs and then nature is willing and capable to repair. Few, however read Hilton's great book and its principles are violated far more than they are observed.

These are surgical examples. No doubt our internists could furnish numerous historical parallels in their procedures. The moral of this is not that one must refrain from taking credit to oneself for pseudo discoveries. That is a harmless vanity if it doesn't lead to recriminations against other claimants. We are taught, however, that proper historical perspective makes for more balanced judgment when we try to evaluate the innumerable suggestions in our literature. Cramming text books

in medical school and noting the most striking articles in journals anxious to fill their pages always has given false values to the indiscriminate. If we know how our predecessors have struggled over these problems we will find their balanced judgments have often gone far to settle our latter day problems.

BENEFICENT COLD?

A recent editorial and some letters to the editor in the Journal of the American Medical Association have presented what must be to nearly all of us a new and startling concept. If there has been one factor upon which all have agreed in the multitudinous discussions of shock since the turn of the century it has been the value of heat in treatment. Shock rooms, shock tables or heaters and blankets have been the prime necessities.

Now some are having the temerity to challenge all this. They say that the low temperature and inertia of shock are protective devices. The bodily functions move at a low rate and hence make less demands on the body's resources.

Of course this sounds absurd to most of us. The value of heat has become an axiom. But as in all biological problems there are so many factors that decision is difficult. We have treated all our shock cases with heat and many have recovered. At the same time we have given them fluids, blood, plasma, etc. We have refrained from any disturbing manipulations; we have kept them quiet by sedatives. Have we really got good evidence that it was because of and not in spite of the heat that they have survived?

At least we know that exposure to cold is not the dangerous matter it is popularly supposed to be. Torpedoed sailors are having their legs submerged for weeks in water barely above freezing without losing those limbs; many a severely wounded man has lain for days in the cold and wet of a Northern France winter and survived. Temple Fay and others may not have demonstrated the curative value of refrigeration but at least they have shown that exceedingly weak sick people can survive long spells of incredible cold without apparent harm.

It is continually being impressed upon us that Nature "works in a mysterious way her wonders to perform". And many of man's altruistic attempts to regulate Nature have been shown to be useless if not harmful. Antipyretics were much used in the past. Now fever is generally conceived of as a purposeful device. Perhaps cold and prostation may often be in the same category. We will undoubtedly see attempts to produce testimony.

ANNUAL MEETING

The 132nd Annual Meeting of the Rhode Island Medical Society will be held on Wednesday, June 2, 1943.

There will be a series of short clinics at the Rhode Island Hospital in the morning. In the afternoon the scientific meeting will be held at the Medical Library.

Last year's social gathering in the afternoon after the scientific meeting was so successful that all the members will be glad to hear that at five o'clock the officers will invite the members and their wives to meet them at the Providence Biltmore Hotel. The Annual Dinner is being omitted this year because of war time conditions so members may privately arrange for dinners after this.

The Charles V. Chapin Annual Lecture will be given at the Medical Library in the evening.

As the American Society for the Control of Cancer is starting its annual campaign with our own Dr. Herman C. Pitts, President for a second year, we are pleased to print their advertisement and also to include the excellent editorial written by Dr. Clarence C. Little.

BEHIND THE DOOR

by C. C. Little, ScD.

Managing Director of the American Society for the Control of Cancer

In any Democracy the forces that stand behind the doctor are quite as important as the training and ability of the doctor himself. Among the public health movements in the United States no group has recognized this basic principle more promptly or more completely than the American Society for the Control of Cancer in conducting its nation-wide educational campaign against that disease.

In 1936 the Society organized as a practical working unit of lay people what it called the Women's Field Army Against Cancer. From the very outset it was specified that this group of lay workers in the educational field should be guided by governing bodies, and the majority of whose members should be medical men or women. The Society and the Field Army thus definitely committed itself to a policy of standing back of the doctor in the fight against cancer.

The wisdom of this attitude has been amply proven. Today doctors all over the United States report a constantly increasing flow of early cancer cases to their offices for diagnosis and treatment. Since the prospect of cure of cancer is directly related to the observation and treatment of the disease in its early stages, this evidence of practical value of the Women's Field Army work has convinced the medical organizations of counties and states throughout the Union that real progress can be made in the conquest of the disease.

The mutual benefits to both the patient and the profession have been great. Either group by itself could never be as strong or effective as in close cooperation with the other. Mutual confidence and respect lead to a development of the best qualities of both groups. This sort of progress will count heavily in determining the progressive advance against this disease in the years to come. We are on our way toward cancer control and both the doctor and the prospective patient can face the future certain that sympathy and understanding will continue to decrease the possibility of conflict and obstruction in the drive toward final victory.

MEN'S VOLUNTEER HOSPITAL CORPS OF THE RHODE ISLAND HOSPITAL

A new development

The Rhode Island Hospital, because of the acute shortage of orderlies, is organizing a Men's Volunteer Hospital Corps. Mr. Matthew W. Goring has generously consented to serve as Chairman of the Corps. Similar Corps have been used successfully for several months at the New Haven Hospital, Hartford General and Massachusetts General Hospitals. The Volunteer Department at the Rhode Island Hospital has asked the Providence Civilian Defense Council to help in the enlistment of lawyers, bankers, pre-medical students, businessmen, and clerks to help in this war emergency. The men who respond to this community need will report before or after business hours or at some period during the week-end. The hours suggested by the hospital are 6:30 to 8:30 A.M. or 5:30 to 9 P.M. or any other time the volunteer may suggest. They will be asked to give at least one period a week. Uniforms with the volunteer insignia will be worn. Various duties including such necessary tasks as setting up oxygen tanks, chopping ice, filling ice collars, cleaning hopper rooms, turning mattresses, rustling bed pans, and taking temperatures will be assigned to the Corps.

The Nurses Training School Office has planned a short course of lectures to be taught by doctors and nurses before the volunteers receive their initiation on the wards. These lectures will start Tuesday evening, April 20th, 7 to 9 P.M. in the Clinic Building at the rear of the Accident Room.

Anyone desiring to enlist in the Men's Volunteer Hospital Corps may apply to Miss Ruth Jennings, Secretary of the Volunteer Office, Providence Civilian Defense Council or to Mr. Matthew W. Goring, 1042 Hospital Trust Building.

WAR SESSION — COLLEGE OF SURGEONS

Another of the War Sessions under the auspices of the American College of Surgeons was held at the Hotel Statler March 15, 1943. The committee on local arrangements was composed of Leland S. McKittrick, Howard M. Clute, Frank Lahey, Roger I. Lee, Harris P. Mosher, James P. O'Hare, Alonzo K. Paine and Michael A. Tighe.

The program was concentrated into one full day of presentations and discussions starting at 9 a. m. and continuing until after the dinner at 6 p. m.

The morning session started with a meeting for Physicians, Surgeons and Hospital representatives with discussions regarding hospital duties in Civilian Defense. This was followed by an address by Dr. A. William Reggio who discussed the Role of Emergency Medical Service in Gas Defense. He showed some motion pictures gotten out by the Shell Oil Co. on what to do in gas attacks. This was a very worthwhile picture. Dr. Reggio pointed out that we should all become thoroughly ac-

quainted with anti-gas technique so that we shall be ready when the attack comes. Dr. Reggio said he firmly believed that such an attack would come before June 1st of this year.

Later in the morning an address was given on the care of the ill and injured in combat zones. All types of injuries of the various organs and parts of the body were taken up in detail by various men interested in special fields and their subjects were discussed by Major Harry J. Warthen, Medical, and Captain Camille M. Shaar, Medical Corps.

The afternoon session was taken up by discussions of the care of the ill and injured after Evacuation from combat zones.

After the evening dinner there was a Panel Discussion on Administrative Adjustments in Professional Staffs of Hospitals in war time. The use of nurses aides and the cutting down of non-essential details was discussed. It was pointed out that boom-day medical frills—hospital rest periods and operations of choice must be out for the duration.

One interesting subject brought out was the danger of explosions occurring under water. Injuries occurring after such under water explosions were usually confined to the abdomen with rupture of the intestines. An example was given where three men were swimming for a life raft. One man had made it and had climbed up out of the water. Another man was swimming breast stroke towards the raft while the third was resting and floating on his back. The explosion occurred from a depth bomb and the man on the raft was uninjured. The man floating was injured but recovered while the one swimming was instantly killed. One can appreciate the danger involved when the sailors have to abandon ship from a destroyer loaded with depth bombs.

It was pointed out that injuries severing tendons and nerves should have prompt treatment and that the proximal ends of tendons should be immediately located and a suture of any material passed through this exposed end, in order to serve as a guide to location at a later date.

This war is no place for the nervous, neurasthenic type of individual, said Dr. Solomon. Care should be taken not to classify a person yellow or timid if he cracks up in battle. The general physical condition plays a great part in determining a man's so called "courage". War fatigue lessens a person's will power and determination.

Dr. James C. White spoke on neuro-vascular lesions of the extremities as found in people saved from the sea after exposure for long time. Those in the North Atlantic had frost bite in the parts exposed to the freezing air. However the open boats always had water in them in which the legs might remain for days. This water was just below the freezing point and the submerged parts did not freeze. There was great swelling though and it was advisable to cut away the shoes that there might be no constriction. If these limbs were treated gently after rescue and particularly the change to warm temperature was made extremely slowly gangrene could usually be avoided and a good result obtained. Shipwrecked sailors in warm waters also had lesions that superficially resembled these but they were caused by long periods of dependent posture without any exercise and with apparently, vitamin deficiency. (Vitamin B)

Medical students from now on are to be parts of the armed forces, will wear uniforms and be on basic pay. This means that no physically unfit men will be allowed in medical school. Internships will be short. It was hoped that women physicians will be allowed to join the WAACS and other similar service organizations, thus relieving male doctors.

It would seem well that the College of Surgeons should continue these sessions in the future as they are of great interest to all medical men during these trying war years.

A General Practitioner interested in First Aid.

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library, April 5, 1943.

The secretary reported for the Executive Committee as follows:

1. That the Executive Committee has approved of a plan to utilize the list of available doctors for emergency night calls directed to the telephone company or the police department through the Physician's Exchange on Thayer Street. All such calls would henceforth be directed to this Exchange as a central directory, and available doctors would be called in rotation, and according to their location in the city to the emergency.

2. That the Executive Committee has approved of a plan to direct a communication to the family

of each member in service with the armed forces to express the interest of the Association in the health and welfare of such families.

The report was adopted.

The President announced the committee of Dr. Ernest A. Burrows and Dr. Gustave Piozzi had filed with the Secretary the Association's tribute to the late Dr. Charles B. O'Rourke of East Providence.

The following doctors were elected to membership.

James A. Alston
Harold Spencer Barrett
John Ross Cranor, Jr.
William Vincent Hindle
William A. McIntyre

Dr. William P. Buffum spoke briefly relative to the need for medical supplies and equipment for the Russian War Relief, and he urged any doctors having such material available for donation to communicate with him or with Dr. Herman C. Pitts.

The President introduced Dr. William E. Ladd, Chief of Surgical Service, Children's Hospital, Boston and William E. Ladd, Professor of Child's Surgery, Harvard Medical School, who presented an interesting paper on "Congenital Atresia of the Oesophagus and its Complications. Dr. Ladd pointed out that this condition is frequently associated with other congenital lesions. There are five main types according to the manner in which tracheal fistulae are formed with the upper or lower segment of the oesophagus. Diagnosis must be early and is suggested by the inability of the child to swallow food and its reaction when fluid enters the trachea. Careful use of lipiodol under the fluoroscope establishes the diagnosis. Of course a gastrostomy is necessary.

He sketched the evolution of the surgical treatment and the method now used at the Children's Hospital. The trachea-oesophageal fistula is tied off and cut by an incision through the back, rope skin grafts are raised from the chest wall and the raw areas skin-grafted; an oesophagus is formed by turning in a tube of skin down the front of the chest, before this the segments of the real oesophagus having been brought out both above and below and their ends stitched to the skin. Finally all three segments of the oesophagus are joined in one tube and all raw areas closed in by the skin from the rope grafts. It entails a multiplicity of operations.

An interesting and graphic movie showed a child now over three years old who took food freely. This was one of four operative cases now alive.

Dr. Edward S. Cameron who did the gastroscopy on the case shown in the movies voiced our appreciation of Dr. Ladd's paper in a graceful manner.

Dr. Wilfred Pickles read a paper on "Bleeding in the Head Following Injury — Some Unusual Examples." Dr. Pickles reported two cases of subpial hemorrhage operated on. One is now alive and greatly improved. A third case was shown at autopsy to be a sub-cortical hemorrhage and he discussed the possibility of recognizing and treating such a case. Drs. McCaffrey and Burrows discussed the paper.

Attendance 87.

FRANK W. DIMMITT, M.D.,
Secretary.

NEWPORT COUNTY MEDICAL SOCIETY

The Staff of the Newport Hospital has spread the following minute on its records.

Dr. Charles W. Stewart, the Chief Surgeon, has finished his many years of skilful service. Words cannot adequately convey the loss to Newport and the Newport Hospital. The lives of the thousands that have come under the ministration of his uncanny skill and his excellent judgment testify more than any words.

Dr. Stewart was a specialist in his chosen field. He prepared himself with one thought, namely, to use his talents in his profession. These talents were recognized as outstanding and were used freely and without stint for his patients. His manual dexterity, his calm and cool judgment, his skill in diagnosis, his intellectual honesty were but a few of the talents that made him a real leader in surgery.

His older associates on the staff of the Newport Hospital can never forget his resourcefulness in helping to solve the many problems that confront all physicians. The younger men of the Staff will always remember his participation in the meetings of the Staff. His comments always carried the seal of sincerity and though given with few words they were recognized as authoritative.

Announcement of

WAR CONFERENCE

Rochester, N. Y., May 24-27

The medical, surgical and industrial hygiene experts who are so ably safeguarding the well-being of more than 20 million industrial workers have agreed to pool their knowledge and exchange their experiences regarding the many new and complex problems of today's wartime production. For this purpose their organizations—

The American Association of Industrial Physicians and Surgeons,

The American Industrial Hygiene Association, and

The National Conference of Governmental Hygienists—are combining their annual meetings in a four-day "WAR CONFERENCE" at Rochester, New York, May 24-27, 1943. Among the problems to be discussed from a practical standpoint are:

The mass entry of women into industry;

Older-age employees, with their various associated problems; proper placement and employability considerations of the 4F rejectees;

Rehabilitation and proper employment of those already discharged from the military services because of disabling conditions;

Toxic and other hazards from new substances, new processes, and the use of substitute materials;

Absenteeism; fatigue; nutrition;

Effects of long hours; double shifts; two-job workers; overtime; increased industrial accident rates;

Advances in the treatment of illnesses and injuries, and many others.

This joint meeting will be a report on the state of the nation, by the men who know, in matters of industrial health. Dr. William A. Sawyer, Medical Director of Eastman Kodak, is General Chairman; Dr. James H. Sterner and Lieut. Comm. J. Bloomfield are arranging the programs for the industrial hygienists.

Physicians and surgeons, hygienists, engineers, nurses, executives—all who are interested in the problems of industrial health and their solution—are invited to attend as many of the sessions as they can arrange for; no registration fee is required.

BOOK REVIEWS

PRINCIPLES AND PRACTICES OF WAR SURGERY, by J. Trueta; C. V. Mosby Co.

Dr. Trueta has as a background for this book his experiences as a war surgeon with the Republican Army of Spain and then as a surgeon in England.

First of all there is an impression of special pleading. He seems over anxious to prove that he and his are the best. In his preface he tells that he has had over two hundred cases at the Wingfield-Morris Hospital with one death. The value of war statistics in these numbers at an established hospital is of course practically nil.

Despite this slight carping we will have to admit that this is a good treatise on war surgery. Beginning with biological principles and history he comes down to the Winnett Orr technique. This he explains in detail and tells of its use. Following this are a number of chapters evolving the philosophy of surgical procedures, — healing of wounds, infections, pyogenic or specialized as gas gangrene and tetanus. The rest of the book naturally is given up to many details of treatment which can hardly be listed in their entirety.

In the last war antiseptic methods were in the forefront, particularly the Carrell-Dakin treatment. Now Trueta emphasizes soap and water, debridement, chemotherapy and the use of Plaster of Paris. Like Bohler he applies the plaster directly to the skin and he feels this aids in drainage because of the absorptive action of the plaster. In the same way he emphasizes the packing of the wounds with gauze for drainage. One look at a cast soaked with blood and serum will convince us that there is tremendous drainage at first but these dressings stay on for weeks. Rarely is there any spreading of the stain in the cast after a few days and the solidly caked gauze would hardly appear to have much circulation of fluid through it.

About one hundred pages deal with details of treatment according to the region injured. The Willems treatment of injured joints with immediate active motion, advocated during the last war and which undoubtedly sometimes gave brilliant results he dismisses thus,— "This procedure has now been completely forgotten — without, I think, any prejudice to the victims of this war". Of course this is in line with the principle of rest in treatment.

Throughout all this regional discussion he stresses the use of plaster for complete immobilization. Even in the final chapter—on burns, he finds use for plaster and presents demonstration of its great functional saving in burnt hands.

We do not know where in one book one will find such a thorough discussion of so many aspects of war surgery or a more clear demonstration of its contrast with peace time surgery.

Psychosomatic Medicine—The Clinical Application of Psychopathology to General Medical Problems—by Edward Weiss, M.D., Professor of Clinical Medicine, and O. Spurgeon English, M.D., Professor of Psychiatry, Temple University Medical School, Philadelphia. W. B. Saunders Co. — 1943.

In line with the recently accepted advances in clinical medicine, and in particular in the general care of the patient, here is a volume which gathers together the present information in its field for presentation to the appreciative reader. This material for a long time was available only by contact with the older and wordly wise practitioners, and then later in the journal bearing the same title as this book. The authors are practicing physicians and teachers in one of this country's larger clinics, who have lead in the development of this topic in the periodical literature, and now take the initiative in the textbook field.

The book itself has a pleasant format, and has as one of its virtues an appreciation of the fact that not every man in practice in these times has the time to read six hundred pages on any single aspect of medicine. The table of contents is therefore full, and the grouping of topics such that the aspects of psychosomatic medicine applicable to one particular field of medicine can be easily selected. Further, in their introduction the authors advise which chapters should be read by all in order to obtain the basic knowledge necessary to understand their discussions. The text reads easily, and presents well both the somatic and psychic aspects of disease. It is well pointed by the selection of actual case studies from the records of the authors, which add to the value of the work by illustration. The topics selected for discussion all have a medical or somatic aspect and therefore are frequently seen by the general practitioner or even the specialist within his field. Likewise they are often stubborn in responding to medical measures of therapy, so that the suggestions as to psychotherapy are very helpful as an addition to the armamentarium of the physician.

In its sections this book presents material on all of the large organ systems of the body. In particular the cardiac and genito-urinary systems are well arranged. The relationship between the heart, the kidney, and hypertension is studied, and the possible role of the phyche in the etiology and pathogenesis of diseases of these organs is skillfully presented. A further summary of the various neuroses related to war is particularly up-to-date, and there is a complete candor about sexual matters in relation to disease.

In all their material the authors preserve a didactic and elementary approach to the problem. Much formulation is used, with the employment of simple diagrams, which have the virtue of making the matter easily understandable, but the fault of appearing derogatory to the reader's own knowledge and understanding in some cases. The final chapters offer instruction in the application of psychotherapy to the physician and are interesting as well as valuable. Their concept of psychopathology and organ language gives a firm footing on which to base their therapy.

Harold S. Barrett

Clinical Diagnosis by Laboratory Methods—Tenth Edition — Todd & Sanford, W. B. Saunders Co.

"Todd and Sanford" has been for so many years a standard text of clinical laboratory methods that there are few physicians unacquainted with it. This new edition retains the usefulness of preceding ones. It now includes most usable laboratory procedures of recent development. Because the field of chemistry is the one of most recent exploration many of these new techniques are chemical in nature.

The authors avoid the prevalent mistake of considering only the new as important. They retain the old and proved methods of bacteriology, serology and cytology. The new edition is thus a concrete example of the fact that the summation of all methods, new and old, is the basis of real value. This book should continue to be of value to the student and to the working clinical pathologist and the medical technologist.

B. Earl Clarke.

Why MILK IS SO VITAL TO AMERICA'S HEALTH—

NO OTHER SINGLE FOOD SUPPLIES SO MANY OF THE PROTECTIVE FOOD ELEMENTS AS MILK

How Milk Supplies the Body's Needs

PROTEIN . . . One quart of milk supplies 1 ounce (30 grams) of protein which is about ½ the minimum daily requirement. It is a complete protein and supplies the substances for growth, for building of muscles and repair of body tissues, but supplies only 4% of the energy required. 1 quart of milk supplies the same amount of protein as ¼ pound of meat.

FAT and CARBOHYDRATE Milk is an important fuel food needed for energy to work and play. The carbohydrate of 1 quart of milk supplies about 1/7 the daily requirement, and the fat in 1 quart of milk supplies about ¼ of the daily requirement.

CALCIUM . . . One quart of milk supplies more than the daily requirement of calcium for both the adult and child. 1 quart of milk also carries almost the daily requirement of phosphorus.

IRON . . . . . Milk is a valuable source of iron. One quart of milk provides about 1/5 of the daily requirement. 2½ glasses of milk will give as much iron as 1 ounce of meat, or 1 egg.

VITAMIN A . . One quart of whole milk supplies about 1/3 the adult's and youth's daily requirement of Vitamin A, and greater amounts for children of different ages, as seen in the chart below.

THIAMINE . . . (Vitamin B_1) One quart of milk supplies about 1/3 the adult's and youth's daily requirement of thiamine, and greater amounts for children of different ages, as seen in the chart below.

RIBOFLAVIN . . (Vitamin B_2 or G) One quart of milk supplies about 4/5 the adult's and youth's daily requirement for riboflavin, and greater amounts for children of different ages, as seen in the chart below.

THE DAILY REQUIREMENTS OF THE BODY — ADULT AND CHILD*

1 ounce = 30 grams — 1 milligram = 1/1000 gram — 1 microgram = 1/1000 milligram

	CARBOHYDRATE GRAMS	PROTEIN GRAMS	FAT GRAMS	CALCIUM GRAMS	IRON MILLIGRAMS	VITAMIN A I. U.	THIAMINE MICROGRAMS	ASCORBIC ACID MILLIGRAMS	RIBOFLAVIN MICROGRAMS
ADULTS: Moderate Activity									
Man (154 pounds)	375	70	135	.8	12	5000	1800	75	2700
Woman (134 pounds)	312	60	111	.8	12	5000	1500	70	2200
Pregnancy	312	85	101	1.5	15	6000	1800	100	2500
Lactation	375	100	122	2.0	15	8000	2300	150	3000
CHILDREN:									
Under 1 year				1.0	6	1500	400	30	600
1-3 years	150	40	49	1.0	7	2000	600	35	900
4-6 years	200	50	66	1.0	8	2500	800	50	1200
7-9 years	250	60	84	1.0	10	3500	1000	60	1500
10-12 years	312	70	107	1.0	12	4500	1200	75	1800
GIRLS:									
13-15 years	350	80	120	1.3	15	5000	1400	80	2000
16-20 years	300	75	100	1.0	15	5000	1200	80	1800
BOYS:									
13-15 years	400	85	140	1.4	15	5000	1600	90	2400
16-20 years	475	100	166	1.4	15	6000	2000	100	3000

* *Adapted from recommendations of Committee on Food and Nutrition of National Research Council, 1941*

Compare the Requirements of the Body with the Food Constituents Supplied by 1 Quart of Milk

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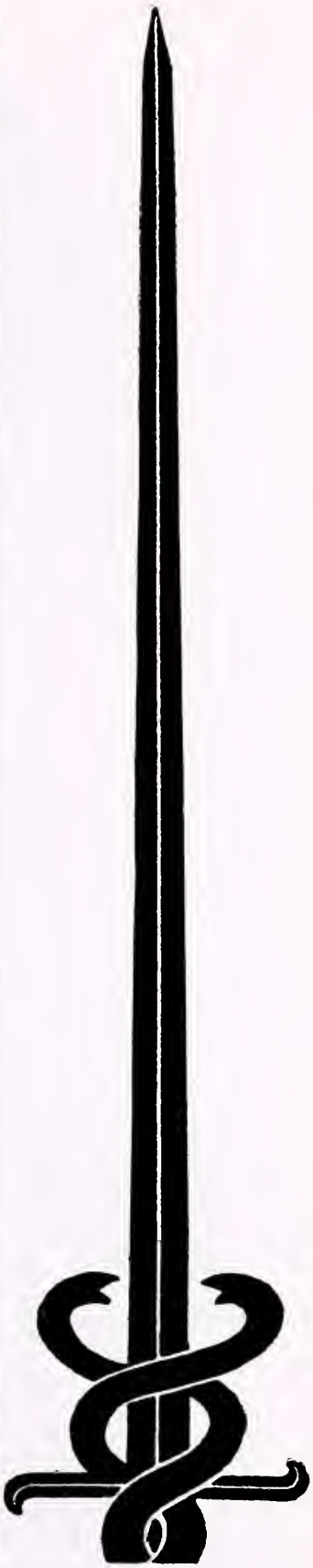


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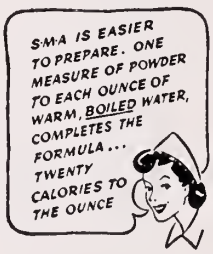
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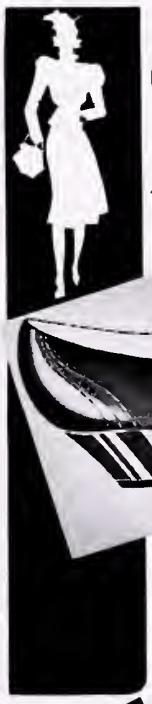
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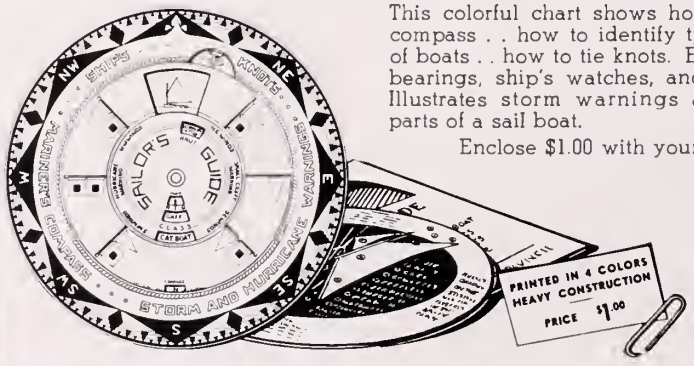
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WEDNESDAY, JUNE 2, 1943

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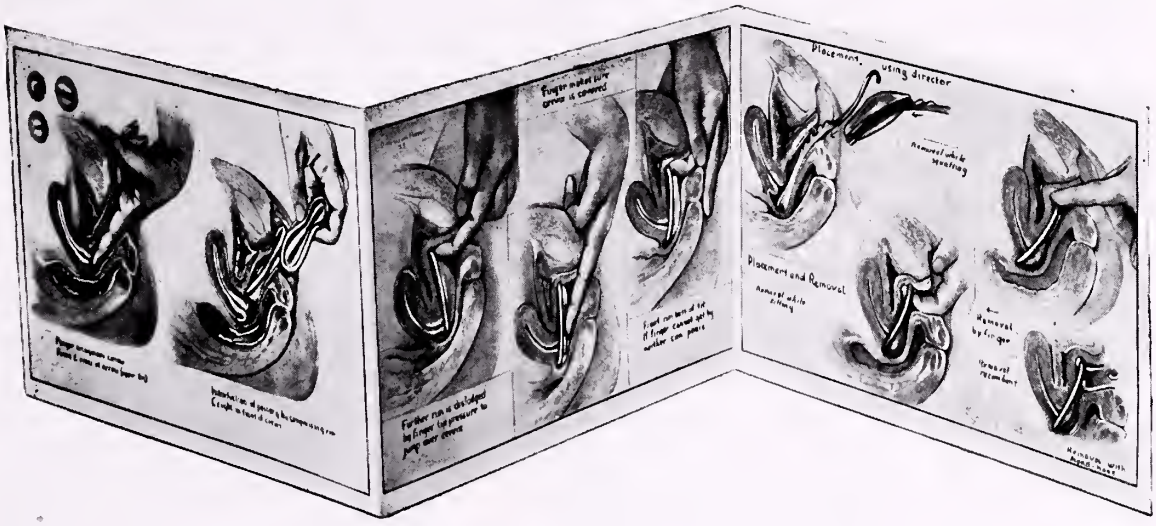
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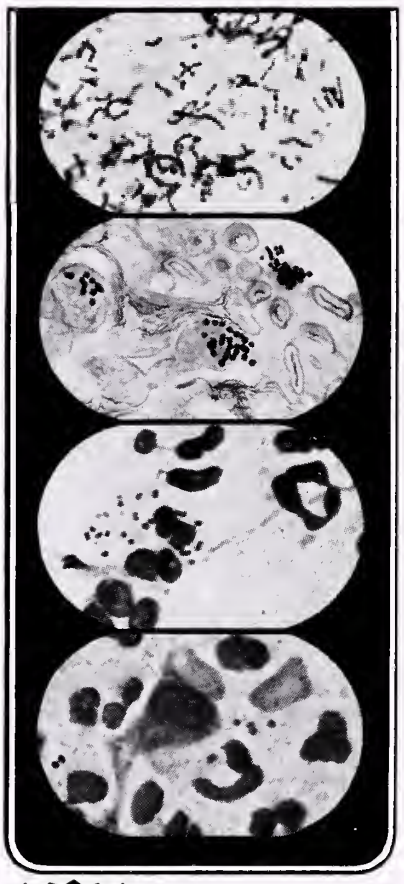
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EXPERIENCE ADDS THE MASTER TOUCH IN THE PREPARATION OF FINE MEDICINAL AGENTS. ONLY WITH EXPERIENCE CAN MANUFACTURING PROCEDURES BE SO PERFECTED THAT THE ULTIMATE IN DRUG AND BIOLOGICAL PURITY IS APPROACHED. THE EXCELLENCE OF LILLY PRODUCTS IS A RESULT OF LONG YEARS OF WELL-DIRECTED EFFORT AND A DESIRE TO MARKET NOTHING BUT THE BEST.

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INHALATION THERAPY

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Inhalation therapy is an important adjunct to modern medical practice. Full advantage of this type of therapy is being taken by too small a segment of medical practitioners because of one or several of the following factors: 1. They fail to understand the indications for this type of therapy. 2. The dangers of oxygen want are not sufficiently appreciated. 3. There exists too little familiarity with the symptoms of early oxygen lack. 4. The characteristics peculiar to the different apparatus employed for inhalation therapy are not widely enough known. Lastly, because of mechanical difficulties the patient does not receive within his tracheobronchial tree the gases which have been delivered from the cylinder.

This paper concerns itself with the indications for gas therapy and the apparatus to be employed.

Compressed gases may be employed in inhalation therapy to accomplish the following:

1. To better supply oxygen to tissue.

2. To effect nitrogen removal from body tissue or cavities.

3. To change the density of the inspired atmosphere so that an increased minute volume exchange may result.

4. To alter the intrapulmonary pressure so that circulatory changes may be effected in the alveoli.

The first and most important indication for inhalation therapy is in conditions of oxygen lack in tissues. This state of decreased oxygen tension in tissue is properly termed Hypoxia. Barcroft and Van Slyke have introduced a very valuable classification for types of hypoxia. This classification is based upon sound physiological considerations. For the purposes of more readily adapting therapy to the types of hypoxia, we have altered and enlarged upon their classification. The following are our considered types of hypoxia:

1. Atmospheric
2. Tidal
3. Alveolar
4. Demand
5. Hemoglobic
6. Stagnant
7. Histotoxic

Atmospheric: By atmospheric hypoxia we mean oxygen lack in tissues due to a decrease in the partial pressure of oxygen in the inspired atmosphere. This state of oxygen hunger concerns the aviator and the anesthetist. It has very little role in ordinary clinical practice.

Tidal: Oxygen lack in tissue as a result of a decreased minute volume exchange results in a condition which we have chosen to term Tidal Hypoxia. The decrease in tidal exchange may be caused by a depressed respiratory center, disturbed respiratory efficiency due to mechanical factors or respiratory obstruction.

Drugs, as morphine, the barbiturates and anesthetic agents may depress the respiratory center and bring about an altered oxygen delivery to tissue and consequently a hypoxia. Oxygen want in tissue as a result of an inefficient respiratory exchange may be due to brain pathology. Respiratory mechanics may be so changed that tidal efficiency is impaired as in intercostal paralysis due to poliomyelitis, spinal anesthesia, or convulsions. Postural changes may interfere with the patient's ability to increase the size of his thoracic cage so that he does not have a satisfactory respiratory volume.

Alveolar: Any condition which interferes with the ability of the alveolus to transmit satisfactorily its quota of oxygen from a normal atmosphere to the circulating blood constitutes alveolar hypoxia.

The functions of the alveolus may be hampered by exudate, collapse or compression. Thus alveolar hypoxia would be the type of oxygen lack suffered by a patient having pneumonia, atelectasis, pneumothorax or pleural effusion.

Demand: An individual may, because of disease, be threatened with oxygen lack even in the presence of a normal atmosphere and a satisfactory respiratory mechanism. Such conditions as hyperthyroidism and fever so increase the patient's oxygen consumption that it is necessary for the patient to increase not only his minute volume exchange but his circulatory efficiency. This threat to the patient's satisfactory oxygen requirement often is followed by an actual oxygen deficit.

Hemoglobic hypoxia exists when there is a lessened amount of oxygen available to the tissue cell due to either an insufficient amount of hemoglobin in the circulatory blood or an altered capacity of hemoglobin to carry oxygen. An example of the former is anemia and of the latter carbon monoxide poisoning may be considered representative.

Stagnant: A slowing or stagnation of the blood would of course result in a decreased efficiency in the transportation of oxygen to the tissue cell. Such decrease accompanies the low blood pressure states which occur in shock or circulatory collapse.

Histotoxic: This last type of oxygen starvation is the result of the inability of tissue to utilize properly available oxygen because of damage due to drugs or disease. A classic example for this type of hypoxia is cyanide poisoning.

Atmospheric, alveolar, tidal and demand hypoxia all are relieved most readily by an increase in the partial pressure of oxygen in the inhaled atmosphere. Patients suffering with hemoglobic and stagnant hypoxia do not benefit so readily. However, in addition to the efforts to remove the causes of such hypoxia, oxygen inhalation here too is important. It must be emphasized, however, that the 15% increase in arterial oxygen which might be effected by satisfactory inhalation therapy makes an important difference in the availability of oxygen to the tissue cell.

Histotoxic hypoxia—this condition of oxygen hunger receives little direct relief from an increased availability of oxygen. The inhalation of oxygen by patients suffering from histotoxic hypoxia would do no harm and would probably improve the patient's general condition.

Nitrogen removal — Fine and his co-workers applied in clinical practice the principle of the physical laws of movement of gases through a permeable membrane. By exposing patients to an atmosphere free of nitrogen it is possible to remove nitrogen from tissue in sufficient volume to relieve such conditons as gaseous distention in paralytic ileus and subcutaneous emphysema. Advantage of this type of therapy could be taken to effect a more rapid removal of gases introduced into the body for such diagnostic purposes as encephalography.

The third indication for compressed gases in inhalation therapy takes advantage of the fact that helium is an inert gas and is of sufficient difference in density from nitrogen that when combined with oxygen it will, on a theoretical basis, pass through constricted channels with a greater degree of speed, efficiency and in greater volume, in a given length of time than will room air. Thus, it is employed in such conditions of respiratory obstruction as asthma.

The final advantage to be taken of compressed gases is in the establishment within the pulmonary tree of a pressure greater than the atmosphere. Barach has been able to demonstrate very satisfactory relief of pulmonary edema using positive pressure inhalation therapy.

To choose properly and employ the mechanical appliance that would produce the results desired in a given set of circumstances it is important: 1. To become cognizant of what may reasonably be expected of the apparatus employed in inhalation therapy and, 2. To know what apparatus will give what is required in the way of end results.

There are several variables to consider as desirable and undesirable effects of inhalation therapy which may be due to the different types of equipment employed. These effects may have a definite action either upon the efficiency of the apparatus or upon the well being of the patient. In the main, they may be considered as follows:

Oxygen Percentage: It is possible to effect higher percentages with some apparatus than with others. Ordinarily, patients suffering from hypoxia would receive as adequate relief as is possible, from a 45 to 50% oxygen atmosphere. When it is desired to remove nitrogen from tissue by

inhalation therapy it is important to remember that satisfactory results may be secured only when nitrogen has been eliminated as much as possible from the inhaled atmosphere. To produce such an atmosphere the patient must be exposed to as nearly a 100% atmosphere of a gas as may be obtained. This mixture of course must contain sufficient oxygen to maintain life. The atmospheres that may be used for this type of therapy may be either 95% oxygen or a helium-oxygen mixture. The latter should contain at least 20% oxygen. It is thus obvious that only an apparatus which is capable of delivering and maintaining such a nitrogen-free atmosphere should be employed in conditions where nitrogen decompression is desired. The same type of apparatus is employed in conditions where a helium-oxygen mixture may be desired, as in the treatment of asthma.

2. Carbon Dioxide Accumulation: Except for the possible effect that carbon dioxide may have upon the oxygen dissociation curve for hemoglobin, this gas has very little place in the treatment of the hypoxic states as previously outlined. Carbon dioxide, indeed, may have a deleterious effect. The authors feel that in our present state of knowledge, the accumulation of carbon dioxide in apparatus employed for inhalation therapy, in the conditions under consideration, should be prevented or kept as low as possible.

Oxygen therapy equipment, at best, may be either confining or irritating such as the pressure of a mask upon the face, or by the presence of a catheter in the oropharynx. Some patients will tolerate some of the methods better than others. Thus, an important consideration for sataisfactory inhalation therapy is the discomfort the apparatus may produce. There should be no hesitancy in changing from one method to another, should the patient be uncomfortable. Providing, of course, that the therapeutic requirements are maintained.

There is no question but that efficiency in treatment depends to a very great degree upon the intelligence and care with which the equipment is maintained. In general, the greater the care the apparatus requires the more likely is it that satisfactory percentages will not be maintained and thus the therapy is apt to be unsuccessful.

With the above considerations in mind, the commonly employed apparatus have been listed and are presented in Figure 1.

INHALATION THERAPY APPARATUS

METHODS	CO_2 ACCUMULATION	O_2 CONCENTRATION	COMFORT	CARE	REMARKS	INDICATIONS
BURGESS OPEN	YES	50-60%	COOL	+++	VALUABLE FOR INFANTS AND SMALL CHILDREN	MOST OFTEN USED FOR HYPOXIA
BURGESS CLOSED	YES	95%	COOL	++++	NITROGEN REMOVAL	
OROPHARYNGEAL CATHETER	NO	45-50%	DRYING TO OROPHARYNX	+	MOST VALUABLE UNDER LIMITED FACILITIES AND FOR MANY PATIENTS. REQUIRES LEAST NURSING CARE	
B.L.B	YES	80%	TIRING	+++	TOO GREAT ACCUMULATION CO_2 EXCEPT IN RAPID FLOWS CO_2 ACCUMULATION IN INVERSE RATIO TO FLOW OF OXYGEN	REQUIRES FULL COOPERATION OF PATIENT
O.E.M.	NO	95%	TIRING	+++	NITROGEN REMOVAL MIXES OXYGEN AND AIR	
O.E.M. POSITIVE PRESSURE	NO	95%	TIRING	++++	PULMONARY EDEMA	CAN DEVELOP POSITIVE PRESSURE
GAS MACHINE WITH CO_2 ABSORPTION	NO	97%	TIRING	++++	PULMONARY EDEMA HELIUM OXYGEN-BECAUSE MOST ECONOMICAL NITROGEN REMOVAL	

SOME PATIENTS WILL NOT TOLERATE ONE BUT WILL TOLERATE ANOTHER OF THESE METHODS
THERE SHOULD BE NO HESITANCY IN CHANGING FROM ONE TO ANOTHER OF THESE METHODS

The Burgess open and the oropharyngeal catheter methods are the most often employed in the treatment of hypoxia. Satisfactory oxygen percentages may be obtained with either at ordinary flows. There is less likelihood of carbon dioxide accumulation in the oropharyngeal insufflation method than in the former. Except in patients who may have claustrophobia the open tent is more readily tolerated. This latter requires much more care and attention to maintain a satisfactory oxygen atmosphere and should be employed only when frequent oxygen analyses can be done. The nasal catheter method is more readily instituted and requires less apparatus. In insufflation methods it is extremely important that the drying effect of the dehydrated oxygen upon the oropharynx be kept at a minimum. Most satisfactory humidification is accomplished by the use of the Emerson apparatus wherein the oxygen is broken up into a very fine stream of bubbles which allows a maximum uptake of water. The Burgess open apparatus is particularly well adapted for the administration of oxygen to infants and children. In these circumstances the "neck" portion of the tent is placed about the abdomen of the child. This is well tolerated by children. Because of the decreased tidal exchange in children, not only must the gases be delivered in fair volume to maintain a satisfactory oxygen concentration but also to wash out carbon dioxide.

The proper use of the Burgess closed apparatus will produce a very satisfactory high oxygen atmosphere. Because of the "closed" apparatus, carbon dioxide accumulation may be great and attempts to reduce this accumulation should be made. An improved mechanism to do this has been developed and will soon be published.

The B. L. B., O. E. M. and O. E. M. positive pressure apparatus are all dependent upon the use of a mask as is the use of a gas machine. The B.L.B. mask allows for rebreathing and thus carbon dioxide can accumulate. The carbon dioxide accumulation in this apparatus is in inverse proportion to the flow of gases. The O. E. M. apparatus is so built that rebreathing can not take place and thus carbon dioxide is well eliminated. This latter apparatus is so constructed that satisfactory volumes of gases for minute volume exchange are delivered by a flow to the bag of well controlled oxygen-air mixtures. The presence of carbon dioxide in a gas machine used for inhalation therapy is dependent of course upon the efficiency of the carbon dioxide absorption medium.

In order to obtain a constant good result by the use of a mask it is important that the mask be tightly fitted and so remain in position. It should be constantly checked for leaks and poor fit. Satisfactory oxygen therapy will not result from the use of a mask on a restless, irrational, or uncooperative patient.

Both the O. E. M. positive pressure mask and the gas machine can deliver gases under pressure to the oropharynx and thus may be employed in those conditions where positive pressure may be desired.

Summary: Hypoxia has been presented in a classification dependent upon the mechanism of its production. The states of oxygen lack which may be relieved have been discussed. Factors which are important in the inhalation therapy of hypoxia have been considered. The apparatus which may be employed in inhalation therapy and their influence upon some of the important factors in this type of therapy have been submitted.

CASE REPORT

of a Recovery From Tetanus in a Five-year-old Child

This patient, B. T., age 5 years, was admitted to the Rhode Island Hospital September 5, 1942 and discharged October 28, 1942.

History of Present Illness:

Five days before admission this young boy received a splinter in his buttock while sliding on an old discarded piece of timber, located in a farmyard. Believing this to be a minor injury, the boy's parents applied a "salve" to the area, no splinters being seen in the wound at the time of this initial treatment. The boy did not complain much about the injury until the evening of his admission to the hospital. He did not feel like eating his supper and said his buttock was sore. Shortly afterwards, he stiffened up and his mother thought he was going to have a convulsion. The local physician was called and after an examination referred the boy to the hospital for further treatment.

Past Medical History:

Measles. No other illnesses or accidents.

Family History and Systemic review:

Noncontributory.

Physical Examination:

Temperature 98.6, Pulse 84, Respirations 28. *General:* A somewhat flushed young boy, not appearing acutely ill, but talking through an almost closed mouth. *Head:* Cranium normal; scalp clear. *Eyes: Ears: Nose:* and *Throat:* Essentially normal. Throat not examined. *Mouth:* Patient cannot open jaws more than a half inch and having difficulty talking—talks through teeth. *Neck:* Rigid. No opisthotonous present. *Lungs:* and *Heart:* Normal. *Back:* On the right buttock there is an oval, indurated, red area, 3 x 8 cm., with a splinter palpable just beneath the skin. *Extremities:* Both legs flexed at the knees. An attempt to extend the legs resulted in rigid extension of both lower legs. *Skin:* Clear; no rashes or eruptions.

Impression:

1. Abscess of right buttock
2. Tetanus

Subsequent Course and Treatment:

Patient was taken to the operating room shortly after being admitted. The abscessed area surrounding the splinter in the buttock was excised under light ether anesthesia. The wound was left open. Specimens taken from the wound were sent to the laboratory for culture. An intracutaneous test for sensitivity to horse serum was done; finding this to be negative 13,000 units of tetanus antitoxin was given intravenously. Following this a lumbar puncture was performed, revealing crystal clear fluid under a pressure of 245 mm. of water. Approximately 10 c. c. of fluid was withdrawn and replaced with 8 c. c. or 15,000 units of tetanus antitoxin.

Several hours after the operation, the temperature began to rise and in less than twenty-four hours, it had reached 105 degrees; the pulse and respirations were also correspondingly increased. There was marked trismus, the teeth being almost locked. Opisthotonus had developed but there were no convulsive seizures. However, bouts of tetanic contractures of the skeletal musculature were precipitated by the slightest stimulation. Barbiturates in the form of sodium luminal and sodium amytal were administered in 2½ to 4 grain doses at frequent intervals with very good effects.

Feeling that there might be an increase of intracranial pressure and because of the severe opisthotonous that was manifested soon after entry into the hospital, another lumbar puncture was done during the first day. The cerebrospinal fluid was found to be under a pressure of 210 mm. of water. After removing some of the fluid and reducing the pressure, the child seemed less opisthotonic. Believing this procedure to be beneficial we performed repeated lumbar punctures during the first three days. Each time the fluid was under increased pressure until the final tap.

Additional antitoxin was given each day up until the third day, a total of 210,000 units being administered. Except for 13,000 units given intrathecally on admission and 20,000 units injected about the site of the wound, all of the antitoxin was delivered by the intravenous route by continuous drip with physiological saline solution.

The temperature continued to remain elevated following the initial operation and on the second day sodium sulfadiazine was given intravenously. This was given in full doses (a grain per lb. body weight) for two days, after which time it was discontinued, there being no response to this form of therapy. Patient's general condition remained poor and the prognosis seemed hopeless.

On the third day, the wound on the buttock was re-explored under local anesthesia. After wider exposure, another splinter which apparently had broken off the original piece and had become angulated and imbedded deeper, was removed. Once again the specimen was sent to the laboratory for cultures. 20,000 units of antitoxin was injected around the site of the wound which was left open.

The spasticity of the musculature persisted and the opisthotonus remained profound and fixed. From the beginning, the patient was placed in an oxygen tent due to the intermittent episodes of cyanosis from respiratory embarrassment. The ever-collecting mucus in the throat and upper respiratory passages precipitated by the many agonizing attempts to regain a normal position, made frequent suctioning essential. A constant vigilance

was maintained, and a dependable, efficient team of nurses played the major role in the ultimate outcome of this case.

The maintenance of adequate nutrition during the exhaustive process was a difficult and trying problem. Unable to pass a Levine tube even after avertin was administered with intentions of relaxing the skeletal musculature, we therefore relied on parenteral fluids. Solutions of dextrose, plasma, whole blood and vitamins aided the patient in withstanding the terrible ordeal.

On the sixth day, the patient developed a diffuse, urticarial rash. This persisted for several days, gradually disappearing. Aside from this clinical manifestation which we attributed to the large amount of antitoxin given, there was little change noted for almost three weeks. The laboratory studies made on the specimens taken from the wound, revealed the clostridium tetani and B. welchi organisms. A piece of the splinter placed in the guinea pig produced tetanus in the animal.

It was not until the seventeenth day that a very small amount of water was taken orally by the child; this was delivered by means of a medicine dropper. Gradually the musculature began to relax somewhat and increasing quantities of nourishing liquids could be tolerated. At this stage, physical therapy in the form of light massage was instituted with remarkedly good results. By the end of the fourth week, the patient was able to walk about with support; the strap muscles of the neck being the last group to relax and return to their normal state.

On October 28, the patient was discharged, fully recovered.

DISCUSSION

One of the chief features of this case is the unusually rapid onset of the disease, the incubation period being but five days. It is generally accepted that there is a direct relationship between the incubation period and the mortality in this disease. Kirtly states that he found 72% of those developing tetanus within ten days of the injury died in one to sixteen days; death followed in only 18% of those developing it ten days or more after the injury. According to different authors the mortality ranges between 30% and 90%. Hill reported 1,264 treated cases with only 414 recoveries.

In the treatment of their interesting case, Chapman and Miller employed six principles, namely:

1. Profound sedation
2. Surgical removal of the focus of tetanus
3. Moderate intravenous dosages of tetanus antitoxin
4. Frequent lumbar punctures
5. Maintenance of adequate respiratory exchange and
6. Most intelligent nursing care.

For the most part, in the management of our case, we followed these precepts. The amount of tetanus antitoxin that we administered, 210,000 units undoubtedly can be considered a large dose, probably more than necessary. As to the amount of antitoxin actually recommended, however, there is considerable difference of opinion. Vener and Bower advocate an initial dose of 100,000 units intravenously and a total dose of about 200,000 units. Spaeth believes that 40,000 to 60,000 units is adequate.

Although we administered a small amount of antitoxin intrathecally during the initial treatment, this mode of administration is generally condemned. Spaeth has presented evidence in support of the theory that tetanus toxin circulates in the blood stream before its final fixation in cells of the central nervous system. He considers the intramuscular and intravenous routes the best methods of administration.

Maintaining proper sedation was an important part of the general therapeutic regime. Barbiturates in the form of sodium amytal and sodium luminal seemed most suitable and effective in this case. Deep sedation without marked respiratory depression could be obtained with care of administration and rapidity of action.

The incomplete removal of the focus of infection shortly after hospital admission, might have accounted for the subsequent prolonged and stormy course. It seems reasonable to believe that the severity of the disease might have been lessened if the entire splinter had been found and removed when the wound was first incised.

Physio-therapy aided considerably in relieving the spastic musculature. As soon as there was a definite improvement in the patient's condition a daily light massage of the back and neck muscles was

instituted. However the muscles seemed refractive to this form of therapy alone so hot fomentations were included in the regime. This was continued each day for thirty minutes over a period of two weeks. Gradually the muscles responded, the strap muscles being the last group to return to their normal state. Mr. Gifford of the Physiotherapy Dept. used an approximation to the Kenny treatment and it apparently was efficacious as in infantile paralysis.

Finally, a word about the nursing care. It played a major role in the successful outcome of the case, indeed the patient may well be considered a living testimony to the benefits of good nursing care.

Summary

1. A recovery from tetanus developing after an incubation period of five days, is reported.

2. A discussion of the treatment and management is presented.

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1943 ANNUAL MEETING EXHIBITS

In spite of the fact that the 1943 Annual Meeting of the Rhode Island Medical Society is to be somewhat abbreviated, most of the firms which sponsored commercial exhibits at last year's meeting will be present. These organizations have expressed great willingness to cooperate in our program, and their financial assistance does much to make the financing of our Annual Meeting a success. Representatives of the exhibiting firms are always deeply appreciative of direct inquiries as to their products from physicians attending the meeting, and a number of the organizations are particularly grateful if attending physicians register with them. The fact that these organizations are willing to support us in a year of difficult transportation and manpower problems indicates their appreciation of the attention we have paid to their exhibits in the past. This can still be definitely improved if more of the attending membership will offer to register with the various exhibitors. This is an opportunity for each member of the Society to lend direct support to an important part of our meeting without inconveniencing himself.

As the 1943 meeting of the American Medical Association has been cancelled, the director of the scientific exhibits for the A.M.A. is supporting the various state meetings by bringing scientific exhibits prepared by the national organization to local meetings. We are fortunate to be able to anticipate the presence of Dr. Thomas G. Hull, Director of the Scientific Exhibits for the American Medical Association, who has offered to demonstrate to us two outstanding exhibits of practical, as well as scientific, interest.

Plans are being made to allow an intermission during the reading of scientific papers for attending physicians to visit the various exhibits. If all visitors can plan to come to the meeting a little early or linger for short periods after the papers have been completed, ample opportunity to inspect and digest the material displayed will be provided. For those who are unable to attend all of the scientific sessions, a few moments at the exhibits at the convenience of the visiting doctor will amply repay the trip to the meeting.

CHARLES BRADLEY
Sub-Committee, Commercial Exhibits

RHODE ISLAND MEDICAL SOCIETY

132nd Annual Meeting

WEDNESDAY — June 2, 1943

President—CHARLES F. GORMLY



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MORNING SESSION

Rhode Island Hospital

8:30. In Operating Rooms—*Operating Clinics*

Peters House Auditorium

B. EARL CLARKE, M.D., *Chairman*

10:30. *Presentations from Staffs of*
ST. JOSEPH'S HOSPITAL
MEMORIAL HOSPITAL, PAWTUCKET
CHARLES V. CHAPIN HOSPITAL
RHODE ISLAND HOSPITAL

Detailed Schedule will appear in official program mailed to members.

1 o'clock. Luncheon, Nurses' Dining Room

AFTERNOON SESSION

Rhode Island Medical Library

2:15. *Business*

Report of Six Cases of Meckel's Diverticulum
ANTHONY V. MIGLIACCIO, M.D.

The Problems of an Army General Hospital
LT. COL. MARSHALL N. FULTON, Chief of Medical Division, Valley Forge General Hospital.

Intermission to see exhibits

The McBurney Incision
MAJOR CLARENCE E. BIRD, Chief Surgeon, Borden General Hospital, Chickasha, Okla.

Rheumatic Fever in Children, Its Recognition and Management
ALEXANDER T. MARTIN, M.D., Clinical Professor Pediatrics, New York University College of Medicine.

Installation of New Officers

5 o'clock. Castle Room, Biltmore Hotel

Social hour for members, wives and guests
Members may arrange for own dinners.

EVENING SESSION

8:30. *Annual Charles V. Chapin Oration*

Changing Views of the Contagious Diseases
DR. EDWIN H. PLACE, Professor of Clinical Pediatrics, Tufts College Medical School.



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Were, by some great cataclysm, all catharticums to cease, assuredly would there firstly be a host of unhappy mortals; but freed from the plague of these vile draughts, with quiet bowels, would man in comfort consort, at peace with his neighbours, and feuds and wars decline.

CANCER EDUCATION

It is a general impression among medical men that results from cancer education have been sadly disappointing. And although there have been encouraging signs of a greater alertness among women in respect to breast tumors and a greater willingness to submit to annual examinations, the fact remains that far too many advanced cases of cancer are coming for treatment.

Surely the great flood of literature, the lectures, the radio talks and the articles in the newspapers must have given every man and woman in the land a pretty clear knowledge of the danger signals that should be reported at once to a doctor!

Is it possible that our plan of education is wrong? That we have been trying to plant a little common sense in the minds of our listeners and have succeeded in planting only fear? Possibly the adult mind with its long experience in living and fully aware of the hazards that surround continuing existence can never bring itself to believe that the symptoms talked about can ever have any personal application. The idea is too terrifying. It has not been grown up with! On the other hand if the same teaching is given to children as part of their regular curriculum, and given according to a well thought-out plan such as the one used in Westchester County, New York, wouldn't they absorb it and carry the knowledge gained on into adult life? The element of fear would not enter their minds. The "cancer age" would seem such a long way in the future that they would accept the teaching as entirely impersonal, but the knowledge gained would be stored away and made use of in time of need.

The experiment is being tried in a number of places and promises much from the enthusiasm with which it is being received. Time alone will prove its real value of course.

A Bill was introduced in the Rhode Island State Legislature this last session making it obligatory for our State Director of Education to give cancer education in our public schools. Fortunately the Bill was lost somewhere in committee. Fortunately, because to work successfully the plan must be a joint enterprise of the State Department of Education, the State Department of Health and the Medical Profession, working through its Cancer Committees.

Rhode Island is a proper state in which to try the experiment. It is to be hoped that in due course of time she will be found in the van of those communities that are leaving no stone unturned in our apparently unending war on Cancer.

WHAT WE LIKE

A big, somewhat overweight city-bred physician a few years ago advised the parents of three slender, healthy girls aged eleven, thirteen and fifteen, not to allow them to climb mountains, a pastime that the whole family was fond of. Another doctor who enjoyed the mountains and indeed all aspects of the wild country encouraged all his children in strenuous sport. The latter remarked, "Isn't it funny; we all tell our patients to do only what we like."

One physician who does not care for swimming is always declaiming the danger of sinusitis follow-

ing this. Are our nose and throat men really the busiest at the season when the beaches are thronged?

It was said that the most exercise Joseph Chamberlain ever took was to walk to a cab. An eighty-three-year-old friend of ours rides horseback daily throughout the year. Each thrived on what he liked. A few years ago a big life insurance company showed in their advertising a soft, pudgy appearing, gray-haired man walking out to the tennis court. The gist of the reading matter with this was, "Be your age. Slow up or you will die of heart disease." But we all know many cases where the attack of coronary came as the sedentary victim was reading, sitting quietly or even lying in bed. Indeed coronary is the professional man's disease; a group not largely represented in the ranks of the physically active.

Many of us know the story of the group returning from a "Temperance Society" on a raw night and meeting an elderly man, thinly clad but evidently comfortable. Asked as to what he attributed his stamina he replied, "I have never used tobacco or liquor." Gratified at this they inquired, "But why are you hanging around on such a cold night?" "I am looking for my old man who is on a drunk," he answered. As we remember the great of the world, few of whom have been teetotalers, and consider that modern studies of alcohol stress Dr. Charles McDonald's aphorism, "Alcohol doesn't hurt good men", we must not be too sure that we are justified in ordering our patients not to drink. Most of them would not mind us anyway.

We all of us like to eat, so before rationing appeared our patients without marked signs or symptoms probably got few homilies from us on the danger of frequent trips to lobster palaces and other popular gormandizing stations. But Joslin and others stress that the most constant factor in diabetes is overweight. And in what condition that we treat do we not find it a handicap?—Except visceroptosis.

When the public are not carping at us for our narrow-mindedness or their agents suing us for restraint of trade, they are asking our advice on these and kindred problems and we, being human, try to pontificate. The greater the ignorance the more the certainty and if you eavesdrop on some of your colleagues—inadvertently, of course—you will hear exceedingly dogmatic statements on matters where you feel a doubt.

It would seem that we can commit ourselves 100% to advising and aiding in avoiding all infections. We none of us like them. Of course in a few generations the race may have lost its immunity and there will be some terrible epidemics but we can't look that far ahead.

But try not to let your personal likes and dislikes influence your advice too greatly. A good motto is, Moderation in All Things.

This goes for your patient's conduct and your admonitions.

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, May 3, 1943. The meeting was called to order by President Emery M. Porter at 8:35 P.M.

The minutes of the previous meeting were read by the Secretary and were approved.

The Secretary reported a communication from the Industrial Health Committee of the State Medical Society announcing an Industrial Health Institute to be held in Providence on Wednesday, May 19, and extending to all members an invitation to attend the sessions.

The Secretary reported for the Executive Committee as follows:

That at the latest meeting of the Executive Committee the report of the Committee on the Executive Secretary of the Rhode Island Medical Society had been accepted, and also that the Executive Committee of the Providence Medical Association had approved of the plan for the consolidation of the present executive office under the joint management and operation of the State Medical Society and the Providence Medical Association.

The Executive Committee had moved that the annual appropriation be made to the Entertainment Committee if in the discretion of the Chairman of that committee and the Executive Secretary of the Association it is deemed advisable to conduct the annual golf tournament and dinner of the Association.

The report of the Executive Committee was approved and placed on file.

The President reported that it was his understanding that the annual golf tournament would not be held this Spring, but it might be held late in the Summer, dependent on conditions existing at that time.

The Secretary reported that the Executive Committee recommended for election to active membership in the Association the following doctors

William Allen Reid
Edward Lincoln Smith

Dr. Jesse E. Mowry moved the unanimous election of both doctors. The motion was seconded and passed.

The President announced that leaflets on tuberculosis suitable for public reading were available through the Providence Tuberculosis League, and he urged members to take copies and place them in their waiting rooms.

Dr. Edmund T. Hackman presented the report of a case of tetanus in a young boy which had an incubation period of only five days following the penetration of the buttock by a splinter from a board in a farm yard. The outlook for a long time seemed desperate, but the patient was eventually discharged after seven weeks, completely recovered. 210,000 units of serum, excision of the focus of infection and the use of sodium luminal and sodium amytal were the main points of treatment. Much credit was given to careful nursing service for the fortunate outcome.

Dr. Russel O. Bowman, Research Biologist of the Rhode Island Hospital, reported on that institution's experience in the use of the Fenwall system of sterile solutions during the past ten months. The cost per liter for the various solutions was reduced from about seventy cents per quart to less than twenty-four cents with a first year's saving of some $6,000 to the hospital. Dr. Bowman presented lantern slides of many interesting tables showing the fluid needs of the body in its various aspects and suggesting the type of fluid to be used parenterally. He called attention especially to the fact that 5% dextrose in water which is isotonic with the body fluids is properly increasing in use, replacing the hypertonic solution of 5% dextrose in saline. Drs. Earl Clarke, Anthony Migliaccio and Eske Winsberg discussed Dr. Bowman's paper.

Lt. Comdr. E. C. Smith of the United States Medical Corps presented a paper on the sexual situation as it concerns the naval personnel. He outlined in detail the methods of instruction which the Navy uses. He reported a most remarkable decrease in the incidence of venereal disease during the period of 1940 to 1942. He reported that the incidence for the Narragansett Bay area is very much lower than that of the service in general. Dr. Smith concluded his talk with the showing of the motion picture in sound produced by the Navy on "Sex Hygiene". A rising vote of thanks was given to the Lieutenant Commander for his excellent presentation.

Frank W. Dimmitt, M.D.,
Secretary

POSTOPERATIVE VITAMIN DEFICIENCIES

Prolonged chronic illness followed by sharp limitation of diet during a period of preoperative preparation, especially when surgery of the gastrointestinal tract is contemplated, may result in a state of partial vitamin depletion. Most parenteral fluids routinely contain glucose, which sets up an additional drain on the vitamin B stored in the body. Post operatively, nausea and vomiting occur frequently and there is often the necessity for complete restriction of food for days at a time.

This sequence of events was clearly reproduced in a case recently reported (Ann. Int. Med., *18*:110, 1943). The patient developed a sore tongue and became uncooperative, disoriented, and confused. A dramatic change ensued after administration of riboflavin and nicotinic acid, with complete disappearance of the lesions within five days.

A number of laboratory procedures have been developed in recent years to augment the clinical diagnostic approach to vitamin deficiency disease, but many of them require special equipment and are not easily adaptable for routine clinical use. Physicians may obtain a list of vitamin values of foods and a bibliography of important and generally informative papers on vitamins by writing Eli Lilly and Company, Indianapolis.

BOOK REVIEWS

Burns, Shock, Wound Healing and Vascular Injuries. Prepared under the Auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. By various Authors. Illustrated. Philadelphia & London. W. B. Saunders Company 1943.

These are four monographs in one volume. Being under the auspices of the National Research Council they are authoritative. The information is basic and condensed. They are not field manuals but cover definite treatment and the chief adverse criticism as war manuals might be that they represent the treatment of surgical conditions caused by trauma rather than treatment of patients under war conditions. However the way is left open for further writing on the practical applications by those experienced in battle conditions.

The bibliography includes reference to some 1942 articles. There is less time lag than usual between the publication of this volume and the current literature.

The article on wound healing is to be especially recommended.

These monographs should be required reading for anyone doing surgery, not for military surgeons alone.

L. C. Kingman

Chemotherapy of Gonococcic Infections by Russell D. Herrold, B.S., M.D. C. V. Mosby Company.

This book is a one hundred and thirty page monograph of eighteen short chapters, in which the author presents a fairly complete picture as to the diagnosis and treatment of gonorrhea in all its phases, with special reference to the use of the sulfonamides.

The author has avoided complicated discussion and is brief and to the point in all he has to say. Here is a book which can be read and digested from cover to cover in less than two hours.

First, he gives the story of the evolution of chemotherapy, next, he discusses each drug separately as to its use, advantages and failings in the management of gonococci infections. Then he discusses diagnosis and various methods of treatment with the drug alone and in combination with other methods of treatment. He gives a rather complete picture of the management of the sulfonamide failures and the so called "carriers" of the disease. Next, he discusses the determination of the cure.

Under the heading of "Unsolved Clinical Problems" he brings out the fact that it is becoming increasingly evident that a number of strains of gonococci appear to be developing the ability to resist all sulfonamide drugs. He warns as time goes on there may be a lowering of the cure rate.

In my practice in the last few months I have noticed an alarming increase in the number of cases in which this fact is borne out. A year ago it was practically safe to tell a patient that his discharge would disappear in forty-eight hours. Now I find that nearly fifty percent of the new cases need additional time and treatment to bring this about.

The author warns of, and fully discusses, all the toxic reactions due to the sulfonamides.

Finally, he presents a series of case histories which bear out all he has said in the previous chapters.

I consider this a well written, worthwhile and timely book.

John F. Streker, M.D.

Gynecology including Female Urology by Lawrence R. Wharton, Ph.B., M.D. W. B. Saunders 1943.

The past of Howard Kelly, Cullen and Max Brodel; the present of Novak, Richardson, the author and a Mr. Leon Schlossberg; and a glimpse at the future of Johns Hopkins' thought are presented in this capable work. The "old saw" that a text book is 10 years old at its birth is disproved by an adequate incorporation of all outstanding work done in the field of Gynecology, as well as a complete bibliography of all essential work up to the beginning of the current year.

The drawings of the late Max Brodel are, of course, adequate but those of the pupil, Leon Schlossberg, seem to be even more appealing to the student of visual anatomy and pathology. Certainly, this medical artist does justice to all illus-

trations bearing his name. Novak's descriptions of pathology and the illustrations are taken freely from his book. The section on "Female Urology" draws heavily on Kelly's "Diseases of Kidneys", Ureters and Bladder"—with considerable addition to the material. The section on "Tuberculosis of the Urinary Organs" and that on "Genital Tuberculosis" are complete.

The book starts off with Anatomy and Embryology and is superior to similar presentations in other text books.

The Endocrinology is simply but adequately presented—using the accepted and trade names of each hormone—in an effort to acquaint the student with the fundamentals of this vast subject. The author sounds a warning note against the indiscriminate use of the glandular products and especially of the synthetic estrogens—"which are sometimes far more potent than the natural substance."

The discussion on menstruation — normal and abnormal is presented in its most modern interpretation. Therapy of dysmenorrhea is thorough and most interesting. He brings home the fact that our knowledge is still incomplete and "emphasizes the many physiologic problems that await solution."

The section on operative gynecology is enlightening both in word and illustrated picture. Naturally, most of the procedures are those of the Hopkins' group, but the work does not suffer due to this fact. Conservatism is stressed in operative work. The too early interference in pelvic infections is pointedly presented. The author has the "obstetrical approach" to gynecology—discussing at length the effects of puerperal infections and poor management of labor on later gynecological problems, as well as the effects of plastic surgery on future pregnancies and deliveries.

Primarily intended as a text book for students, it is the best in modern circulation. For the general practitioner there is medical and operative gynecology with gynecological pathology and female urology—four books condensed into one. For the specialist it is an excellent summary of many monographs plus very adequate illustrations. It can be recommended to any person with even the slightest interest in gynecology or female urology.

John F. Murphy
April 20, 1943

"Manual of Industrial Hygiene and Medical Service in War Industries" issued under the auspices of the Committee on Industrial Medicine of the Division of Medical Science of the National Research Council and prepared by the Division of Industrial Hygiene National Institute of Health, U. S. Public Health Service.

Published by W. B. Saunders Company and edited by William M. Gafafer, D.Sc., Senior Statistician U. S. Public Health Service, this work is the result of the efforts of sixteen leaders in the field of Industrial Hygiene, including physicians, dentists, educators and sanitary engineers.

It is the most complete work on Industrial Hygiene yet published, and should be in the library of every physician engaged or interested in Industrial Medicine.

The physician just starting in Industrial Medicine will find the chapters on organization and operation of plant medical services of immeasurable value. Never has the relationship between Industry and Medicine been more clearly defined or more succinctly stated.

To the physician established in Industry and faced with changes in manufacturing procedures as well as the use of newer chemical compounds—this book offers a brief but complete coverage of the dermatoses.

Diagnosis and treatment are detailed—but best of all—the methods of the control of occupational hazards are clearly defined.

The Industrial Sanitary Engineer can profit as well as the physician in a study of the chapters on Fatigue — Nutrition — Illumination — Ventilation and Plant Sanitation.

The chapters on Manpower—Women in Industry and Absenteeism are quite statistical but so well written that they are never dull and thus serve to round out the complete coverage of Industrial Medicine.

Charles Laurence Farrell, M.D.,D.M.D., Phar.D.

Excerpts From

THE DOCTOR OF MEDICINE AND HIS RESPONSIBILITY*

ALFRED W. ADSON, M.D.
ROCHESTER, MINNESOTA

It is the duty of every doctor of medicine to prevent illness, to supply adequate medical care to those who are ill, to perpetuate the science of medicine and to encourage medical investigation. It is true that the average physician would prefer to go unregimented among his sick and administer to their needs, irrespective of race, color, creed, or financial status, rather than busy himself with administrative and political problems. However, since the courts have ruled that group health is a business and have found that medical societies are guilty of restraining trade when attempting to maintain the standards of the practice of medicine, a challenge has been issued to the medical profession: Is there a necessity for lay groups and the Federal Government to take over the control of the practice of medicine. . . . . .

The medical profession recognizes the necessity of state and federal control of communicable diseases and medical services to inmates of state and federal institutions. It appreciates its responsibility to the Armed Forces and expects to supply the needed personnel. It is willing to co-operate with welfare agencies in providing adequate medical care for the low income and indigent groups of the population; but in providing this care, it believes that the medical service is augmented when the patient-physician relationship can be maintained by permitting the patient, wherever possible, to choose his own physician. In order to protect the public from worthless, so-called medical procedures and unnecessary operations by unscrupulous individuals, it likewise believes that high standards of medical education and practice must be maintained. This applies not only to the practice of medicine in the office, it applies to the practice of medicine in the humble home or in the most modern hospital. . . . . .

Therefore, we as physicians believe that a more equitable solution of the perplexing medical problems referred to will be reached if we are permitted to consult and advise administrative officials, legislative bodies, and welfare agencies, since we are more familiar with the medical needs of our respective communities than are those who have a casual knowledge of the medical necessities. . . . . .

The functions of acquainting the public on matters of medical interest, assisting bureaus in formulating plans on medical care and offering constructive advice on proposed medical legislation rightfully belong to the national organization known as the American Medical Association. They could be assigned to the National Physicians' Committee, or they might even be undertaken by unifying the activities of the various state committees on public policy and legislation. Representative committees could be appointed for each of the component societies, county, state, and national. These could all be so integrated that national opinion and advice could be obtained and made available for committee hearings or legislation within a few hours' time. Through the national, state, and county committees the entire profession could be informed of proposed medical legislation. Thus, the local constituents of the respective state and federal legislators could express their views before legislation is enacted. Some states already have medical advisory committees from each county. They also have state medical committees on public policy with a physician as part-time executive chairman assisted by legal counsel. A national committee constructed on the same plan as these state committees would have to be created. A physician who has practised medicine should be chosen as the executive chairman. Both he and his legal counsel would need to be stationed in our national capitol. The expense of the national committee on public policy could be financed by one of three agencies, the American Medical Association, the National Physicians' Committee, or the respective state organizations bearing the expense jointly. It would appear more equitable if each physician would be assessed each year for the specific purpose of maintaining a national committee on public policy and legislation.

Our problems are not unlike those of dentists and hospital associations. Therefore, unified effort of medical, dental and hospital associations should further the welfare of the patient.

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*Read at the meeting of the National Conference on Medical Service, February 14, 1943.

PEDIATRIC ANTIQUES ON TOUR

It has been well said that more progress has been made in pediatrics during the past three or four decades than in all the time before that.

As applied to the feeding part of pediatrics, the Mead Johnson Collection of Pediatric Antiques bears eloquent witness to the great strides made. Without such evidence, it would be difficult, indeed, to imagine our own grandparents being fed from some of these odd-shaped utensils that defied thorough cleansing. To be sure, sterilization and pasteurization were not then in vogue. Not all babies received breast milk in abundance. In the days when wet nurses were common, some of these enterprising women literally did a wholesale business, managing to nurse three or four infants.

The baby's cereal of a century ago was simply stale bread lightly boiled in water, wine or beer. Butter or sugar might be added but the use of milk was regarded as fraught with danger. It was thought, according to Dr. T. G. H. Drake, "Milk might bring on the watery gripes, or the infant might imbibe with the milk the evil passions and frisky habits of the animal supplying the milk."

From a personal hobby enjoyed by the late E. Mead Johnson, Jr., the Collecton of Pediatrics Antiques, illustrated in the pages of a catalogue just issued, has evolved into one of considerable historical importance, depicting as it does the progression of infants' feeding vessels from the Greece of twenty-five centuries ago down to time within our own memory.

The Collection has been steadily growing in size and scope and is of increasing interest for teaching purposes via the historical route. The destruction of original sources caused by the war tends to add to the value of these objects.

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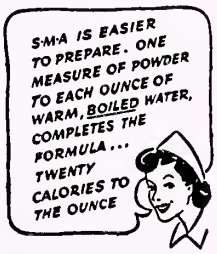
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RHODE ISLAND MEDICAL JOURNAL

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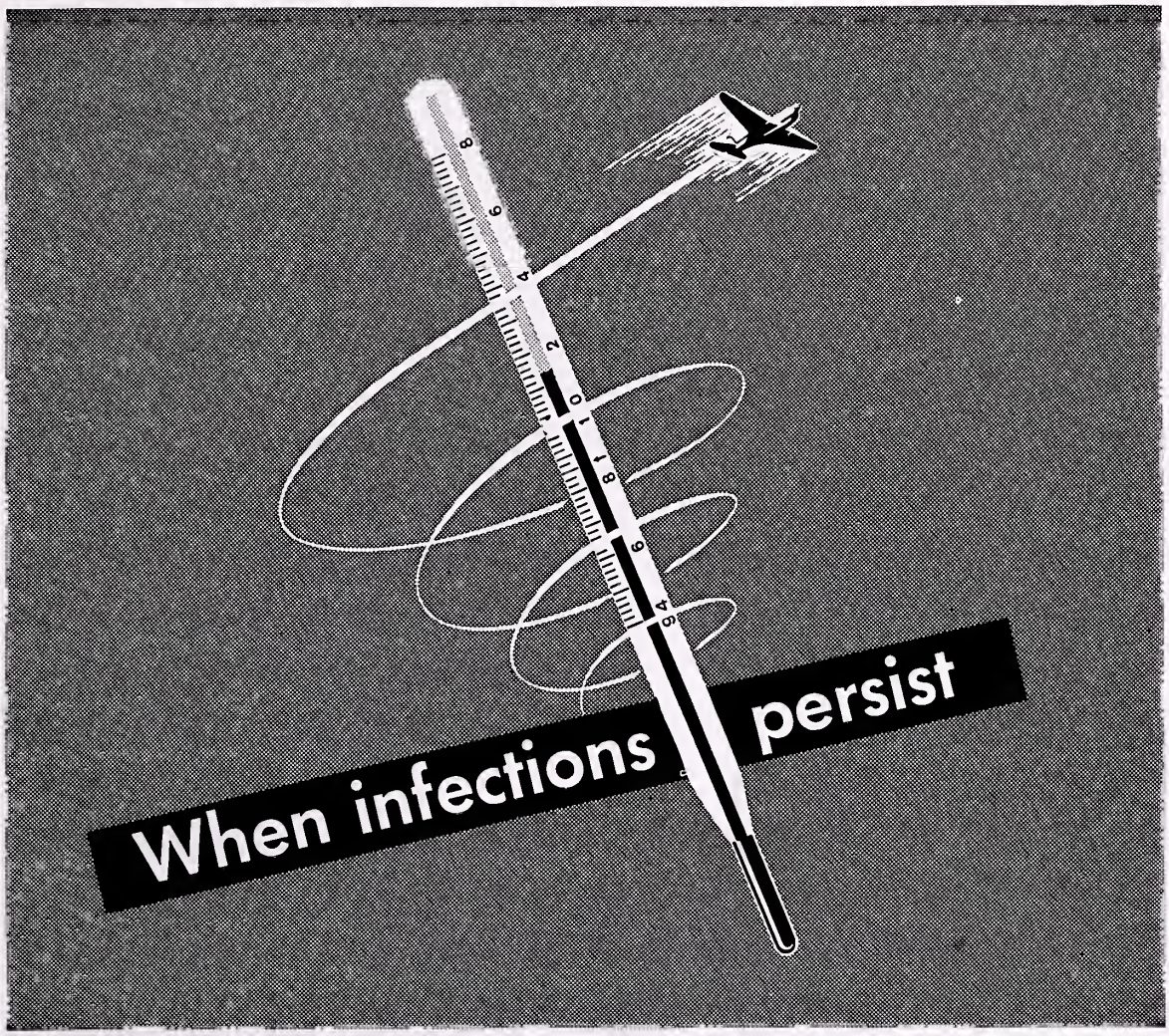


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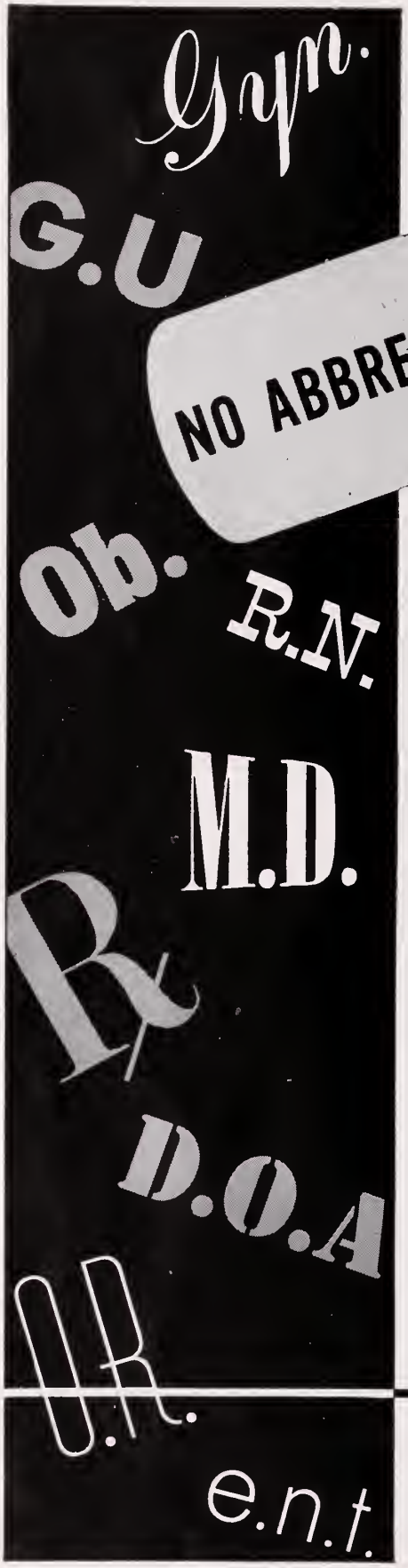
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*Welch, H., and Brewer, C. M.,: The Toxicity-Indices of Some Basic Antiseptic Substances, Jl. of Immunology, Jan., 1942.

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154. Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60. Proc. Soc. Exp. Biol. and Med., 1934, 32, 241. N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*

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Principles of Extraperitoneal Caesarean Section

By JAMES V. RICCI, M.D. *and* JAMES PRATT MARR, M.D.

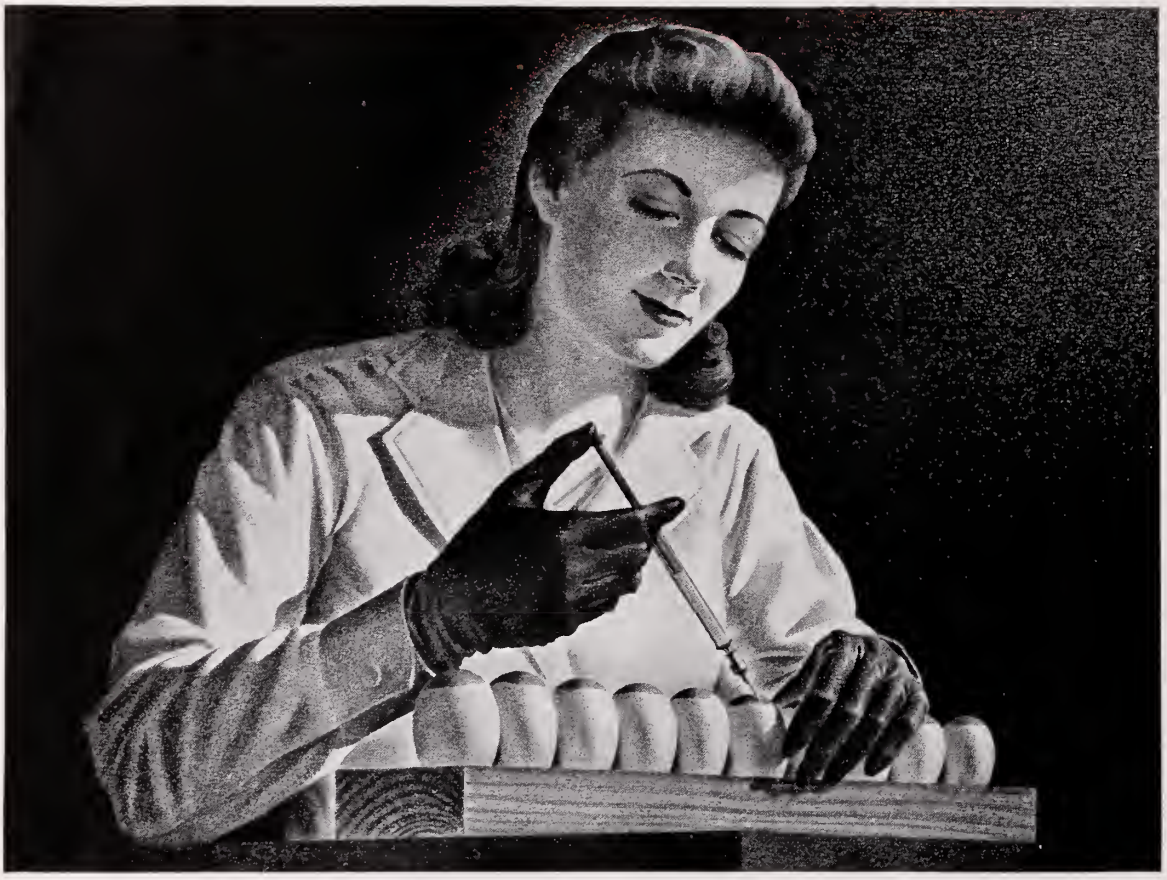
Of the highest authenticity, comprehensive and compact, this book points the way toward a synthesis of obstetrics and gynecology. It gives, for the first time in detail, the technique of all kinds of extraperitoneal caesarean. It is the first book to give clear descriptions of the anatomic relationship between fascia transversalis, peritoneum and bladder in the various stages of pregnancy.

The New England Journal of Medicine, says: "This monograph should prove of value to the obstetric specialist and serve as a ready reference to writers on the subject."

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THE RHODE ISLAND MEDICAL JOURNAL

Volume XXVI JUNE, 1943 Number 6



MURRAY SNELL DANFORTH

President, Rhode Island Medical Society
Chief of Staff, Fracture Service, Rhode Island Hospital
Ex-Chief of Staff, Orthopedic Service, Rhode Island Hospital
Editor, Journal of Bone and Joint Surgery
Died, June 5, 1943

OVER AND ABOVE THE CALL OF DUTY

The Rhode Island Medical Society may fittingly issue a posthumous citation to our late President, Murray Snell Danforth. Such a citation honors the recipient, not as the holder of our highest office, but as one who by his life and works exemplified the highest personal and professional ideals. Though deprived of the opportunity to benefit from his leadership in these difficult times, our membership and the whole profession has already benefited from his unselfish friendship and professional integrity. We are the poorer by the loss of our friend but much the richer for his having lived with us. His teaching by word and example of the meticulous care of the patient with all that involves in work, knowledge and conscience has directed the flowing stream of internes and colleagues along channels of sure advancement. He carried the torch and passed it on.

SEX HYGIENE IN THE NAVY

Lt. Comdr. E. C. Smith, M. C. USNR.

Sex Hygiene and Venereal Disease Control play a decisive role in the preservation of the health of the Navy. From time immemorial Venus and Mars have gone hand in hand. As the Duke of Milan once said, "When my men stopped talking about women, I knew I was defeated."

Mindful of the lessons learned during World War I, when 7,492,510 service days were lost to the Armed Forces as the result of venereal disease, the Army, Navy, U. S. Public Health Service, and the Federal Security Agency, in 1940 formulated an eight point program.

This program was adopted in anticipation of war and was aimed at the control of such diseases, not only in the military personnel, but in civilian population as well.

When this program was adopted the admission rate for the Navy was 80.27 per 1000 per year.

The admission rate for the Newport Area was 12 per 1000 per year.

In 1942 the rate of all of the Navy fell to 36, while the rate for the Newport Area dropped to 5, a decrease of 58 percent from 1940.

The admission rate of syphilis to gonococcus infections is 1 to 6.46.

To provide trained officers for the Venereal Disease Control Program, the Navy shortly after the outbreak of the war, began enrolling certain Medical Officers in the School of Hygiene and Public Health at Johns Hopkins University. Many such officers are now assigned to bases, Training Stations, and other activities where there are large concentrations of men.

It is the duty of such an officer, after having studied the conditions in the particular locality, to formulate a plan best fitted to cope with the situations.

Thus in Rhode Island, where the venereal disease rate is extremely low and excellent cooperation is obtained with the civil authorities, the program differs from one which would be indicated elsewhere.

Read before the Providence Medical Association, Providence, Rhode Island, May 2, 1943.

No amount of activity will be successful unless it is thoroughly understood and appreciated that the crucial factor is the human element.

It is the problem of the man in uniform. It must be realized that many of the men coming into service have their own solution of sex life worked out. If the man has been promiscuous beforehand, he will be promiscuous as a sailor, the man who was continent will probably remain so. Donning a uniform does not change a man's sex habits, but in certain cases accentuates them.

It is the impression of the Army that 15 percent of its men are promiscuous, 15 to 25 percent are continent, and that 70 percent are in a formative, plastic state. These figures may well be applied to the Navy personnel.

Most people do not realize how the ordinary sexual urge may be intensified when men live under discipline and restrictions in stations and on board ships. Sex is the favorite topic of conversation, of stories, and songs, and everywhere may be found the self-styled Don Juan who brags about his conquests.

Let us consider the man going on liberty. He is out for a good time, and often comes ashore without any definite plans. If he has any relatives, friends or acquaintances in the vicinity, he will get in touch with them. The average man craves feminine company. He wants a girl to talk to, to dance with, to share a meal with. A decent girl is preferred.

Unfortunately his liberty usually is of short duration, often too short to enable him to meet the proper girl, but girl he must have.

He is an interested sightseer in new places, but his capacity along such lines is limited.

Too often he is likely to be a stranger in a seaport city where after walking the streets and standing around the corners, boredom drives him to the tavern or beer garden and the percentage girl or pickup.

Thus he finds a good time in good company in the town where there are constructive recreational facilities and returns to duty benefited by his leave.

If the town is indifferent to his welfare and permits his exploitation he may return damaged both in morale and health.

To counteract these pernicious influences the Navy has undertaken to present the principles of Sex Hygiene to every member of its personnel.

The group basically concerned is the younger men, those with more plastic minds and habits, and less reliable information.

Education starts in the recruiting station where each man as he signs up, is given a leaflet, "To A Young Man Entering the Navy."

In the past many a boy picked up a venereal disease during his final spree prior to entering service.

In keeping with the trend to audio-visual methods of education, the Bureau of Medicine and Surgery has made a film, "Sex Hygiene".

This film describes the common venereal diseases and stresses the importance of prophylactic measures.

It has been made available to all naval activities and is shown together with a lecture which is followed by a question and answer period.

Each recruit attends such an exercise shortly after his induction at the training station.

A pamphlet, "Sex Hygiene and Venereal Disease", covering prophylaxis and general disease information is given each man on leaving the lecture.

The program does not cease with the completion of recruit training, but is continued wherever the man goes, both on land and afloat.

For the sailor who is promiscuous the importance of prophylaxis must be stressed.

There are three (3) methods of prophylaxis:

(a) *Mechanical:* which aims at the prevention of contact between a normal mucous surface with one containing infectious lesions. e.g. Condon or rubber sheath, the most effective single measure against venereal infection. It protects both the male and female parties in the sex act. It is easily carried and readily available. This should be used in combination with other measures of prophylaxis.

(b) *Chemical:* which aims at the destruction of Treponemas and gonococci on the skin or mucous surface, before their penetration into deeper tissues.

(e.g.) 1. Washing with soap and warm water.
2. Injecting protargol solution 2% 4.c.c. into the urethra, hold for 5 minutes before expelling, and
3. The application and rubbing into all exposed parts of calomel ointment.

(c) *Chemotherapeutic:* which aims at the destruction of gonococci which may already have penetrated through the surface to deeper tissues.

(e.g.) Oral administration of sulfathiazol to men who have been exposed as late as 24 hours following the contact. The dosage is usually 4 grams in divided doses.

Self administered prophylaxis is not particularly effective because of:

(a) *Ignorance of the procedure*
(b) *Carelessness*
(c) *Intoxication*

Supervision of prophylaxis is most essential. This is carried out by hospital corpsmen who have been specially trained, in stations set up for this purpose. Such stations are located in all sick bays, at boat landings, railroad stations, and often in the so-called "Hot Spots".

Station prophylaxis if taken within one hour after exposure, prevents infection in the great majority of cases, after the second hour the protection value rapidly diminishes.

In the epidemiology of Venereal Disease the reduction of contacts play an important role in lowering the rate of infection. There are two factors to be considered:

1. The source of infection or the reservoir of infection in the civilian population.
2. The ways and means whereby naval personnel contact infected women.

In considering the reservoir of infection, all prostitutes must be considered potentially infectious. In nine naval districts prostitutes over a period of eight months in 1942 were responsible for 21.5 percent of infections. In the same areas for the same period "pickups" were responsible for 64.4 percent and girl friends for 13 percent.

Repression of prostitution is a civilian activity. The term repression is used because it is realized that prostitution is one of our oldest professions and can never be entirely suppressed.

No city, by any system of medical inspection, has yet been able to safeguard prostitution from spreading infection.

In my opinion a doctor who issues a certificate giving a prostitute a clean bill of health comes under the classification of an abetter of prostitution.

The prostitute in the brothel is trained and aided to make far more contacts than her sister the street walker or the clandestine prostitute.

Today we have the problem of the pickup. She is a girl who works by day and entertains by night. She meets the man in uniform on the street, in the movies, at the roller-skating rink, the dance hall, night club or tavern. She is on the make and for an evening's entertainment will indulge in sexual intercourse. Her taste is legion and she often has a different partner each night.

The teen age girl enters the picture with astonishing frequency. I have personally seen girls of this age stop sailors on the street.

Then we have the "sea-gull", or the girl who follows the fleet. For bed and board she will pose as a wife. She is often passed on to a shipmate when her man is ordered away.

There are the hostesses and waitresses in night clubs and taverns, many of whom work on a percentage basis.

And last, but not least, we have the "facilitators". Any and all who make it easy for healthy men to meet and be exposed to infected or possibly infected women. The direct facilitators are: the madams, pimps, and procurers; the indirect: landlords of houses of prostitution, owners and managers of taverns, cheap hotels and dance halls, taxi drivers, bellhops and doormen.

Finally we come to liquor, which has been well-termed, "the lubricant of the facilitation process." Strict enforcement of the laws pertaining to the sale and conduct of the establishments where the sale of liquor is permitted would go far in controlling this danger.

Effective control of venereal disease requires the closest cooperation between the service and the civilian health organizations. Any sizeable concentration of naval personnel complicates the local problem. The venereal disease rate in any given naval activity reflects the efficiency of the control program of contiguous communities.

The discovery of the recognized infections, especially those which are in the early and communicable stage constitutes an important phase in the control.

Thus contact investigation has become as essential in venereal disease control as in any other communicable disease. The Navy has delegated the responsibility of contact reporting to the Medical Officer. It is his duty to see that the local and state health authorities are furnished with accurate and adequate information regarding the contacts of infected personnel.

The follow up work devolves upon the civilian health officers, who must trace the contacts named and see that prompt and adequate treatment is instituted if they are found to be infected.

The Medical Officer must restrict all personnel with infectious lesions until the danger of spread is passed. Hidden cases may be discovered by frequent surprise examinations. The dangers of concealment and improper treatment must be impressed upon the men.

Finally a program for prompt diagnosis and adequate treatment must be established.

Today, when the country can ill afford to lose the service of any able bodied man because of a preventable disease, the Navy seeks the cooperating of all agencies, military and civilian, to keep as many men at as many guns as many days as possible.

The opinions or assertions herein are the private ones of the writer and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

PRESENTATION OF PORTRAIT OF CHARLES F. GORMLY, M.D. TO THE RHODE MEDICAL SOCIETY*

By Roland Hammond, M.D.
Providence, R. I.

We are assembled on an auspicious occasion—to dedicate a portrait of a President of the Rhode Island Medical Society, while he is occupying that high office. Only in one previous instance has the Society so honored itself. Sixteen years ago a portrait of Dr. Charles V. Chapin was unveiled in this room in a fitting ceremony. This evening you have listened to a Charles V. Chapin oration founded by

*Read before the Rhode Island Medical Society, June 2, 1943.

the Society in honor of the great investigator of communicable diseases. Tonight we do homage to our President in recognition of the outstanding work which he has done and is now doing for humanity and the medical profession. This talent for accomplishment which he so ably exemplifies has endeared him to us all.

About thirty-two years ago a young physician returned to his home town and established himself in medical practice. It soon became evident to all who met him that he was destined to become "The Boy who made good". After a preliminary education in Providence schools, he had been graduated from Tufts College Medical School in 1909. There followed an interneship of three years at the Boston City Hospital,—one year on the medical service, a similar period on the neurological service, and a final term at the South Department. The splendid work of this branch of the Boston City Hospital has just been ably demonstrated by the present Physician-in-Chief of that Department.

After settling in Providence, Doctor Gormly immediately became associated with hospital practice. Between 1911 and 1924 he received the various promotions from medical externe to visiting physician at the Rhode Island Hospital. For the past four years he has served as Physician-in-Chief to the Hospital. His administration of this important position has given free scope for his outstanding qualities of leadership. His conduct of a Medical Grand Rounds of a Saturday morning is a revelation of medical practice and bedside teaching at its best. The valuable instruction, interspersed with spontaneous Irish wit and humor, is an experience never to be forgotten by one who has witnessed such a clinic.

Doctor Gormly joined the Providence Medical Association in 1912 and the Rhode Island Medical Society in 1914. He served as President of the former association in 1934. It was during his term of office that he conceived the idea of redecorating and improving the acoustics of the assembly hall,—a problem which had baffled architects for twenty years. The funds for this project were generously donated by the Providence Medical Association. During his earlier years in practice he directed the medical work at the John W. Keefe Surgery.

In 1916 Doctor Gormly enlisted in the British Army and received the honorary rank of Lieutenant in the Medical forces. He served for one year in northern France, the English midlands and in London. When our country entered the World War he enlisted in the American forces, as a Captain and was later promoted to the rank of Major. He served as Physician-in-Chief to the 13th Evacuation Hospital in France. He is now a Lieutenant Colonel in the Medical Reserve Corps, U. S. A.

Following the cessation of hostilities he resumed his practice and served for a time as Consultant at the local office of the Veteran's Bureau, where he succeeded in bringing order out of chaos to the satisfaction of everyone concerned.

Doctor Gormly's hospital staff appointments and medical society memberships read like a page from *"Who's Who"*. He is consulting physician to most of the hospitals in the State. In addition to the local medical societies, he is a member of the American Medical Association, the New England Heart Association, and the American College of Physicians. He holds that coveted testimonial of merit,—certification as a Diplomate of the American Board of Internal Medicine.

For many years Dr. Gormly was a member of the Tufts Alumni Council, and by his advice and faithful attendance was a valuable addition to that body.

Our friend has always been famous for his abounding energy. He has never walked if he could accomplish more by running. His mind has been as active as his body. Early in his career, he interested himself in medico-legal problems. Because of his discerning insight into the other fellow's problem and his skill and diplomacy in reconciling difficult and often baffling cases, he is held in high esteem by all the physicians and dentists of the State.

Several outstanding and pithy lectures delivered by Doctor Gormly endure in our memories. A few years ago at a Sunday afternoon lecture in this room, sponsored by the Rhode Island Medical Society, he spoke upon the fascinating and popular subject: "How to Grow Old Gracefully". You will remember that the hall was filled to capacity, and every listener felt well repaid for his attendance.

Some 25 years ago Dr. George Washington Gay, a well known Boston surgeon of a previous generation, was convinced that certain practical subjects, such as medical ethics, professional conduct, success in practice, and the business side of a physi-

cian's life, were not adequately taught in the medical schools of his day. At his death he bequeathed a fund to both Harvard and Tufts Medical Schools to found the George W. Gay Lecture on Medical Ethics. This lecture is delivered each year before students in both of these schools. The speaker is selected for outstanding achievement and success in upholding the highest ideals of the medical profession.

Consequently this community was overjoyed about two years ago to learn that *our* Doctor Gormly had delivered the Gay lecture before the student body of the Tufts Medical School. The subject chosen was: "The Measure of a Physician's Greatness". The address has received wide and favorable comment, and is one of the great modern contributions to the ethical side of medical practice. By its very human quality it admirably depicts the age-old relation between physician and patient in the highest ideals of the medical tradition.

During the past winter the Rhode Island State Dental Society tendered a testimonial dinner to Charles F. Gormly, M.D. and presented him with a Medal of Award and Scroll. The citation accompanying the Award is as follows:

"GREETINGS:

The Rhode Island State Dental Society grants to you this day the medal of award and citation of the Society.

The grant was decided because of your devotion to obligation and duty; because of your dynamic energies that allowed nothing to interfere with your desire to always serve those who asked your services.

We have noted that it made little difference to you whether the call came from the private patient or whether it came from the ward in a hospital.

The Rhode Island State Dental Society has recognized your leadership, your ability in education and your fostering spirit that gave many interns courage to venture forth into the practice of medicine.

Beyond this also your fatherly care has watched over them, ever willing to lift them up and spur them on. When necessary you knew when to be sympathetic and when to be severe.

We honor you because you have been ever ready to fight to preserve the principles of the Profession you love so much: Medicine.

We honor you, Doctor Gormly, because you have honored Dentistry. You have helped us by your wisdom freely given. We greatly appreciate your accomplishments in the field of medico-dental and legal associations. We honor you because of your friendship.

THE RHODE ISLAND STATE DENTAL SOCIETY
Thomas W. Clune, D.M.D., *President*
Charles F. McKivergan, D.M.D., *Secretary*
January 27, 1943."

And only two weeks ago came another honor to be added to the long list bestowed upon him in appreciation of his good deeds. The Faculty of the School of Nursing of the Rhode Island Hospital has established the Charles F. Gormly award, and the following citation was delivered by Mrs. Edward J. Coleman, R.N., Director of Nurses and Principal of the School, at the Commencement Exercises on May 19, 1943.

"At Commencement, it is traditional to recognize by award an outstanding student. The Faculty of this school wish to carry on this tradition by establishing an award in honor of one of the members of this Faculty; a Doctor whose high ideals and standards in the practice of his profession has stimulated all nurses to maintain the highest in the practice of their profession. He is a man loved and respected by all. He has been a valuable friend from whom we all have been able to seek advice and guidance in professional and personal problems. He has for many years been interested in and contributed in every way possible to the advancement of nursing education in the Rhode Island Hospital.

Because of this, we of the Faculty wish to honor him by establishing an award, to be given to an outstanding senior student nurse, for the furthering of her professional interest.

She must be a nurse who meets in every way the requirements as set forth in the aims of the School of Nursing of the Rhode Island Hospital and must be one who gives the greatest promise of contributing not only to the nursing profession, but also to the community in which she may



Portrait of CHARLES F. GORMLY

Artist, F. ZAKHAROW

Presented to the Rhode Island Medical Society
by fellow members of the Society

As the fund for this purpose was over-subscribed it is intended to give the remainder towards the endowment of the Charles V. Chapin Annual Oration, this having the enthusiastic approval of Dr. Gormly.

live. And so, it gives me great pleasure to present the first Charles F. Gormly award to Miss Sylvia Blanche Pigeon."

But enough of eulogy. This occasion signifies a more personal devotion and evidence of brotherly affection.

Charlie Gormly: You have received honors and acclaim beyond the lot of ordinary men. More than all the evidences of esteem and distinction which have been heaped upon you, we wish you to know that we love you for your own self, for your great qualities of helpfulness and your intuitive discernment of the problems of your fellow men. We are confident that your motives are always directed to the betterment of medical practice. We value your great friendship for this ancient profession, for your interest in each and every one of us, for your ability to get us to labor together, and to keep us a collective, harmonious working body. You have given ample proof of your ability as a great coordinator and have carried the Society through a difficult year to a berth in a safe harbor. You have consoled and comforted many a patient, but by your example you have also shown your colleagues how to enjoy life to the fullest extent.

The portrait which is about to be unveiled is a contribution from your many medical friends throughout the State as a tribute of their personal devotion to you, and also of their appreciation of your many accomplishments. It is presented to the Rhode Island Medical Society as a perpetual reminder of your achievements and will serve as a stimulus to generations of Rhode Island physicians in the years to come.

* * * * * * *

One of the ancient traditions of the Rhode Island Medical Society is the office of Anniversary Chairman. The officer has two functions: (1) to wear a dress suit at the annual dinner of the Society, while all the other Fellows and guests are garbed in every day clothes. The dress suit is not being worn this year. (2) To serve as presiding officer at the annual dinner. The annual dinner is not being held this year.

Consequently it gives me great pleasure to introduce the Anniversary Chairman, Dr. John G. Walsh, who will now unveil Doctor Gormly's portrait.

REPORT OF STATE CHAIRMAN FOR PROCUREMENT AND ASSIGNMENT OF PHYSICIANS, TO THE MEDICAL PROFESSION OF RHODE ISLAND

Presented at the Annual Meeting, Rhode Island Medical Society—June 2, 1943, Halsey DeWolf, M.D., Chairman.

The Rhode Island Committee for the Procurement and Assignment of Physicians derives its authority from the War Manpower Commission. Its Director, Paul V. McNutt, in February 1942, personally appointed the Committee's Chairman, who, at the time, was Chairman of the State Medical Preparedness Committee of the A.M.A., with instructions to him to designate other members. There seemed no more appropriate nor representative choices for such members than the Ex-President, President, President Elect, and Secretary, of the Rhode Island Medical Society. As constituted then the Committee was and now is composed of Doctors Kingman, Hussey, Gormly, Buffum and myself as Chairman — Dr. Danforth's name will soon be added. From the first, directives from Washington, with which the members thoroughly agreed, led the Committee to adhere to several basic principles:

1—While its primary duty is to aid in supplying medical personnel to the armed forces, hardly less important is its responsibility in protecting the civilian home front from lack of professional care:

2—The welfare of the groups, military and civilian, is first to be considered, and secondarily the personal desires of the individual physician:

3—The question of availability for military service or essentiality in civil practice, must be considered by the Committee wholly from the professional and not the social viewpoint. To amplify this—a man of suitable age is practically always considered available, unless he is absolutely needed in his community, his hospital or in public service, and is proved to be irreplaceable. (This last important point I shall refer to later.)

4—The Committee's relation to the individual doctor, the hospital, public service and industry should be one of close cooperation, with constant effort to be helpful in solving problems as they arise:

5—The closest relation shall be maintained with Selective Service Headquarters, as well as with the Local Draft Boards, to assure, so far as possible, a mutual knowledge of the draft possibility of the individual doctor:

6—Finally, this Committee shall approach its problems free from prejudice or personality and prepared to judge each case on its merits, after fair and free discussion with all concerned. In our own belief, we have maintained throughout this impartial attitude.

The general procedure followed by this Committee, (frequently changed by directives from Washington) would be tedious to recount and is hardly pertinent to this report. Briefly; a card for each doctor in the State has been set up, upon which, in addition to many basic facts, a record is kept of all events bearing upon his possible military service. Numerous consultations have been held, by individual members of the Committee; a great many of the men of military age coming in for discussion or advice. In this way, the Committee feels it has functioned helpfully. From time to time, Committee meetings have been held, much routine business done, and important decisions rendered in doubtful or borderline cases.

As the work progressed and more experience was had with the many problems which arose, a number of interesting facts developed.

Whereas, in the earlier period, it was believed there would be a considerable number of individuals on the Staffs of the several hospitals, who, for various reasons, must be classified as "essential" this proved not to be so; Hospital Staffs were depleted, (many by 30-50%); supposedly key men entered military service and yet the hospitals functioned with reasonable satisfaction. Methods were simplified, services combined and some cancelled for the duration, while Consulting Staffs were called back into active service. Eventually, it was seen that, with the exception of some Laboratory and X-Ray personnel, it was the rare man on a Hospital Staff who was truly irreplaceable and so should be classified as "essential."

It was apparent that the cities and bigger towns of the State were for the most part, well stocked or even overstocked with doctors and so could supply a larger relative percentage than the country districts. In some of the latter the P and A Committee classified a few men of military age, who were irreplaceable, as "essential." It may be added; no man who was sincerely anxious to enter the service was prevented from doing so by being classified "essential."

Both Army and Navy Procurement Stations, the Offices of the Surgeons General, all Recruiting Offices, as well as Selective Service Headquarters and Local Boards throughout the State do not consider an applicant for a commission until he is classified as "available" by his State P and A Committee. As a result, with the exception of interns commissioned before graduation and men enrolled early in Hospital Units, all those receiving commissions have been cleared through this Committee.

We have also watched closely for any Area in the State which bid fair to become depleted of civilian medical personnel and been somewhat surprised to find that, to date at least, no such Area exists.

A few figures as to quotas, enrollments, etc., may be of interest.

Early in 1942, when the P and A Committees were set up, the A.M.A. listed approximately 950 physicians in Rhode Island, of which about 850 could be considered active in one branch or another of medical work; of this number (850)—396 were 45 or under and so to be considered for military service. As quotas for 1942 were given out to the various State P and A Committees, that for Rhode Island was 186—which proved to be the exact number commissioned on December 31, 1942; in other words, purely by chance, our State scored 100%.

The number of presumably healthy men of military age who were "disqualified for physical disability" caused surprise. It is probable we do not yet know the full number in this group. It includes however, many of your colleagues who have volunteered, some repeatedly, to enter military service, only to be rejected. Though their names may never be known, to them as well as to those who received their commissions, all honor is due.

For 1943, with 8,000-10,000 more doctors needed by the military forces, Rhode Island is asked to supply about 70 additional men. The method of enrollment differs somewhat from that used last year and though well conceived, seems destined to

partial failure unless there arises a more vigorous and patriotic tendency than at present to volunteer. If and when the regulations governing Selective Service reach out for married men with children, there will of necessity be a considerable increase in commissioning of doctors, which possibly may accomplish the desired result.

Finally, it may be of interest to the entire medical profession of Rhode Island, whom we are now addressing, to know the impression gained by this Committee on P and A, after more than a year's intensive work in helping to furnish medical personnel to the armed forces as well as in trying to guard the home front from too great depletion of medical care. Admitting the truth that Doctors, perhaps, have more to lose by going to war than anyone else, it is our belief that in such a time of national emergency, men fall into three classes:

1—Those who are selfish, willing to stay at home and accept the financial and other rewards to accrue from the absence of those in service:

2—Those whose sense of personal duty to the country and feeling of responsibility in guarding its welfare are balanced by the hardships of leaving home and practice; who are perfectly negative, as it were, but ready to go if they must: and

3—Those who are thoroughly patriotic and do not count the cost, but *go*.

Where do you stand?

THE RHODE ISLAND MEDICAL SOCIETY

Officers and Committees Elected for the Year 1943-1944

President ..... Murray S. Danforth, Providence
President-Elect ..... Elihu S. Wing, Providence
Vice-President ..... Michael H. Sullivan, Newport
Secretary ..... William P. Buffum, Providence
Assistant Secretary ..... Alfred L. Potter, Providence
Treasurer ..... Dr. Jesse E. Mowry, Providence
Assistant Treasurer,
Charles J. Ashworth, Providence

Committee on Public Laws
William H. Foley, *Chairman*, Providence
Earl F. Kelly, Pawtucket
Lewis B. Porter, Providence

Committee on Publication
Alfred L. Potter, *Chairman*, Providence
John F. Kenney, Pawtucket
Augustine W. Eddy, Woonsocket

Committee on Medical Education
Jesse P. Eddy, 3rd, *Chairman*, Providence
John Langdon, Providence
G. Raymond Fox, Pawtucket

Committee on the Library
Herbert G. Partridge, *Chairman*, Providence
Samuel Adelson, Newport
Adolph W. Eckstein, Providence

Committee on Arrangements
Edward F. Burke, *Chairman*, Providence
Charles Bradley, Providence
Charles O. Cooke, Providence
Roland Hammond, Providence
George Waterman, Providence

Committee on Medical Economics
Herman C. Pitts, *Chairman*, Providence
Lucius C. Kingman, Providence
Alex M. Burgess, Providence

Committee on Industrial Health
Charles L. Farrell, *Chairman*, Pawtucket
Herbert E. Harris, Providence
Stanley Davies, West Warwick

Auditors
Joseph W. Reilly, Woonsocket
Thomas A. Egan, Providence



THE RHODE ISLAND MEDICAL JOURNAL
Medical Library Building
106 Francis Street, Providence, R. I.

PETER PINEO CHASE, M.D., *Managing Editor*
122 Waterman Street, Providence, R. I.

Associate Editors

CHARLES BRADLEY, M.D. — JOHN C. HAM, M.D.
ALEX. M. BURGESS, M.D. — JOHN W. HELFRICH, M.D.
FRANCIS H. CHAFEE, M.D. — ALFRED M. TARTAGLINO, M.D.
FRANK B. CUTTS, M.D. — ERNEST D. THOMPSON, M.D.
JOHN H. GORDON, M.D. — GEORGE L. YOUNG, M.D.

Committee on Publication

ALFRED L. POTTER, M.D. *Chairman* — CHARLES F. GORMLY, M.D. *ex officio*
JOHN F. KENNEY, M.D. — WILLIAM P. BUFFUM, M.D. *ex officio*
AUGUSTINE W. EDDY, M.D.

The truth may make us free; however, not knowing what is ultimate truth, physicians should be a little cautious in thrusting their own brand of it down patients' psychosomatic throats.

EDITORIAL, *N. E. Journal of Medicine.* May 20, 1943.

THE ANNUAL MEETING

The Annual Meeting was a great success. In the forenoon at the Peters House there was a series of ten talks of ten minutes each given by members of the staffs of the Memorial Hospital, Pawtucket, the Charles V. Chapin, St. Joseph's and Rhode Island hospitals. Dr. B. Earl Clarke arranged these and saw to it that they went off like clock work, a factor which always contributes to the success of a meeting. The subject matters were interesting and well treated but the outstanding excellence was that man after man, often without notes, appeared to have all his material at his tongues end and presented it like a well accustomed but still enthusiastic member of a medical faculty. It was an inspiring exhibition.

Immediately following this the Rhode Island Hospital was host at a tasty luncheon. The eyes of one of our returning army men gleamed as he remarked on the delight of having again a delicious lobster dish. Would that our hospital staff in India could swap their curried meats for some of this.

At the Medical Library there was a good display of commercial exhibits despite the shortened meeting this year. At the back of the lecture hall the American Medical Association had an interesting series of charts dealing with the barbiturates, their attributes, difficulties and dangers, their use as a means of suicide and a descriptive list of the thirty or so mostly used.

The hall at the afternoon meeting was well filled, as it frequently has not been in the past. Dr. Migliaccio presented his remarkable series of six cases of Meckels Diverticulum operated upon. Dr. Martin of New York gave an authoritative talk on Rheumatic Fever. Dr. Bird came back from Oklahoma to talk on the McBurney Incision. Dr. DeWolf gave an informative talk on Procurement and Assignment and Dr. Marshall Fulton told us about the set up of a General Hospital, especially the one at Valley Forge, apparently as big as all that George Washington had in the whole country.

In the middle of the program there was an intermission, it being pointed out that this was to visit the exhibits. Although there had been a carefully supervised closure of windows on this, the hottest and most humid afternoon of the year, that outstanding anaerobic organism, the medical profession, had no need to come up for air.

Dr. Gormly did not read the President's Address, stating that it would be printed later, and then Dr. Danforth, although evidently an exceedingly sick man, with the indomitable spirit that characterized his life came forward and assumed the Presidency with a few words of appreciation and a modesty in extreme contrast to our sense of his worth.

A pleasant party was then held at the Biltmore, the members, wives and friends being the guests of the officers. It was nice to see there some of the wives of members absent in the armed forces.

At the evening meeting Dr. Place, as the Charles V. Chapin Orator, gave a scholarly talk on The Changing Views of Contagious Diseases. It would be difficult to find one more fitted to speak with authority on this subject.

After this Dr. Danforth called upon Dr. Hammond to present to the society the portrait of Dr.

Gormly. The recital of the high points of Dr. Gormly's life and his achievements was a most felicitous tribute to our friend and leader. Dr. Walsh, who had been chosen by Dr. Gormly for Anniversary Chairman, unveiled the portrait painted by F. Zakharow of New York.

Unfortunately our zealous Council of Defense gave raucous warning of a hypothetical German air raid in the midst of this interesting ceremony, interrupting Dr. Hammond's talk in the middle and allowing the audience insufficient time to be spectators. Mr. Zakharow is an artist of high standing and we will all look forward to viewing the portrait in its proper setting in our library.

We all took shelter in the ensuing darkness, and when there was light, dispersed, feeling that the Annual Meeting had been a good climax to a great year under Dr. Gormly.

A NEW JOURNAL

The *Providence Medical Journal* is to be reorganized and, we trust and believe, improved. Therefore we print on our editorial page the report to the House of Delegates of the Committee on Publication telling of the plan and somewhat of our anticipations.

REPORT OF THE COMMITTEE ON PUBLICATION

At the meeting of the Council of the R. I. Medical Society on May 12th it was voted that the Committee on Publication report to the House of Delegates at this annual meeting on May 20th on the suggested combining of the monthly publication of the Providence Medical Association, *Medical News,* with the R. I. MEDICAL JOURNAL. The Committee has met in consultation with the editors of the two publications, Dr. Peter Piñeo Chase and Mr. John E. Farrell. Largely as a result of their very harmonious and expert cooperation the following report is offered for your consideration and action.

In the first place let me preface my remarks by reporting that the Executive Committee of the Providence Medical Association has approved the consolidation of their publication with that of the state society.

Medical News, as you can easily recall because of its relatively short life, has been an expansion of the post card notices of the monthly meetings of the Providence society. Under Mr. Farrell's energetic secretaryship it has increasingly performed an important function in our medical community. The post card has become a self-supporting, going concern. It has outgrown its birthplace. It is too helpful and important to have only its present parochial field.

With Mr. Farrell's becoming Executive Secretary of the state society it has seemed logical that, in his new office, the secretary might well continue to use this instrument or at least certain departments of his publication in his larger sphere. It seems very desirable for other medical communities of the state, for the other component groups of the state society, to be served by and jointly to support by contributions of news, articles, and editorials such a common publication. It is suggested that the JOURNAL be expanded to include such features as News from the Fronts, Personals, Medical Economic News, legislative reports, and other current information.

The JOURNAL can continue to carry out the original function of the News in announcing the time, place, and program of the Providence society. It can also do this for all the other county and local societies. This will require only that the secretaries of the local societies do their part in sending this and all other news to the editor. The release date of the JOURNAL can easily be changed if necessary to accommodate the JOURNAL to this helpful function.

There are some members of the Providence society, I am sorry to say, who are not members of the State society. To those few recalcitrants post card notices can be sent, or, for a time the JOURNAL might be sent to them in place of such a notice. They might thereby become interested in joining the state organization.

The suggestion is made that the managing editor of the *News* be made the managing editor of the JOURNAL to supervise the business side of the publication. It is also suggested that he be urged to continue his contributions to its editorial and news pages which have been of such uniform excellence. Dr. Chase is to continue as editor-in-chief.

The technical details of the merger can best be worked out by Dr. Chase and Mr. Farrell. The consolidation would involve the transfer of what advertising is not common to both to the JOURNAL. The size of the JOURNAL would be increased by the inclusion of new features. It is confidently expected that the publication will enlarge pari passu with the increased service which it hopes to offer to the doctors of the state. A study of costs of printing can be left in the hands of the managing editor. Because of the increased facilities of the office of the Executive Secretary of the state society the mailing of the JOURNAL through this office instead of by the printers might expedite or lower the cost of publication.

To the committee there seems to be no good reason why the merger of the two publications will not be advantageous to all concerned.

The committee feels that Mr. Farrell would make no small contribution to the state society in giving his brain child to the RHODE ISLAND MEDICAL JOURNAL and desires to take this opportunity to thank him for his whole hearted cooperation.

Respectfully submitted,
ALFRED L. POTTER, M.D., *Chairman*

DR. HUSSEY

Dr. Frederic V. Hussey, who died early on the morning of June 15th, was one year ago President of our Society, to which he gave freely of his constructive talents and wise counsels.

One of the best Surgeons in the State, perhaps one of the best that Rhode Island has ever known, both in technical skill and superlative judgment; his professional attainments are too well known to all of us medical men to dwell upon in this short memoir.

If, more than anything else, the measure of a man is his personality, Dr. Hussey stood at the top; dignified, self contained, yet always ready to mix freely in intercourse with his fellows; with a great capacity for friendship, he was singularly able not only to give but to receive confidence, offer and accept sympathy, in short, to enter fully into the lives about him.



FREDERIC V. HUSSEY, M.D.

His influence spread far beyond the medical world, as witnessed by the hundreds of laymen who gathered last year at the great dinner in his honor; two of his outstanding characteristics shone out in what he said that evening—his sense of humor and his modesty. He thought it something of a joke that he should be so honored. It is certain that he was one of our beloved physicians and while we shall miss his splendid professional work, upon which so many depended, we shall miss more the "Fred" Hussey whom we all have known so well and loved.

A great doctor is gone, but we may be sure that all the good things for which he stood will carry on into the indefinite future.

RHODE ISLAND MEDICAL SOCIETY

SECRETARY'S REPORT

May 20, 1943

The membership of the Society on May 1, 1943 was 596. This is exactly 100 members more than we had two years ago. There are 132 members in the armed forces and thus the members at home are 32 less than in 1941. During the year, 49 new members have joined the Society, 2 members have been reinstated, 13 members have died and 3 have had their membership discontinued.

During the year, the new Rules and By-laws have been adopted. The reorganized Council has had two bimonthly meetings. At these meetings the Council nominated a list of officers to be presented to the House of Delegates at the May meeting and also made recommendations to the House of Delegates in regard to several matters of importance.

In accordance with the vote of the House of Delegates at the January meeting, arrangements have been made by the Council to install Mr. John E. Farrell as Executive Secretary of the R. I. Medical Society on July 1st. Before that date he has unofficially assumed a good deal of the burden of the Secretarial Office.

The May meeting of the House of Delegates will be the first meeting of the reorganized House. At this time the members will be the five senior officers and the elected delegates. The Chairmen of the standing committees and the Editor of the JOURNAL are invited to be present but are not voting members.

Under the new Rules and By-laws there are two new standing committees. The Committee on Medical Economics is entirely new, and the Committee on Industrial Health was formerly appointed by the President.

All these changes have given us the structure of a strong and efficient society and we can confidently look forward to a period of greater usefulness to the public and to the medical profession of the state.

Respectfully submitted,

WM. P. BUFFUM, *Secretary.*

HOUSE OF DELEGATES

The Annual Meeting of the House of Delegates was held in the R. I. Medical Society Library, Thursday, May 20th at 8:30 P. M., Dr. C. F. Gormly, the President, presiding. There were twenty-seven present including the members, the chairmen of standing committees, the Editor of the JOURNAL and the newly appointed Executive Secretary.

The minutes of the January meeting were read and approved.

The report of the Council, covering the March and the May meetings was read.

Dr. Murray S. Danforth was elected President for the year following the Annual Meeting on June 2nd. Dr. Elihu S. Wing was chosen President-Elect and Dr. Michael H. Sullivan, Vice President. The following list of officers and standing committees were also elected:

Secretary: Dr. William P. Buffum.

Assistant Secretary: Dr. Alfred L. Potter

Treasurer: Dr. Jesse E. Mowry

Assistant Treasurer: Dr. Charles J. Ashworth

Committee on Public Laws: Dr. William H. Foley, Chairman; Dr. Earl F. Kelly, Dr. Lewis B. Porter.

Committee on Publication: Dr. Alfred L. Potter, Chairman; Dr. John F. Kenney, Dr. Augustine W. Eddy.

Committee on Medical Education: Dr. Jesse P. Eddy, 3rd, Chairman; Dr. John Langdon, Dr. G. Raymond Fox.

Committee on the Library: Dr. Herbert G. Partridge, Chairman; Dr. Samuel Adelson, Dr. Adolph W. Eckstein.

Committee on Arrangements: Dr. Edward F. Burke, Chairman; Dr. Charles Bradley, Dr. Charles O. Cooke, Dr. Roland Hammond, Dr. George Waterman.

Committee on Medical Economics: Dr. Herman C. Pitts, Chairman; Dr. Lucius C. Kingman, Dr. Alex M. Burgess.

Committee on Industrial Health: Dr. Charles L. Farrell, Chairman; Dr. Herbert E. Harris, Dr. Stanley Davies.

Auditors: Dr. Joseph W. Reilly, Dr. Thomas A. Egan.

It was voted that the Trustees of the Fiske Fund be authorized to employ counsel to put the Fund on a sound financial basis.

It was voted that the recommendation of the Council for increase in salaries of the Librarian and the Assistant Librarian be adopted.

It was voted that the Treasurer be instructed to supply funds for the construction of another room in the rear of the auditorium in the library building for the uses of the Society.

The report of the Treasurer was accepted with approval.

The report of the Secretary was accepted.

The report of the Committee on Public Laws, Dr. Foley, Chairman, was accepted.

The report of the Committee on Publication, Dr. Potter, Chairman, was accepted and it was voted that its recommendations be adopted.

The report of the Committee on Education, Dr. Eddy, Chairman, was accepted.

The report of the Library Committee, Dr. Partridge, Chairman, was accepted.

The report of the Trustees of the Library Building, Dr. Wing, Chairman, was accepted.

The report of the Necrology Committee, Dr. Streker, Chairman, was accepted.

The report of the Committee on Arrangements for the Annual Meeting, Dr. DiLeone, Chairman, was read and accepted.

A letter from the Pawtucket Medical Association in regard to duties of the physician under the Sickness Compensation Act was referred to the Medical Economics Committee.

An informal letter from the Executive Committee of the Indiana State Medical Association favoring the rescinding of the resolution of the House of Delegates of the American Medical Association which approved the activities of the National Physicians Committee, and also favoring the establishment of an office of the American Medical Association in Washington, was read and discussed. No action was taken on the subjects in this letter.

The meeting adjourned at 10:15.

Respectfully submitted,

Wm. P. Buffum, *Secretary.*



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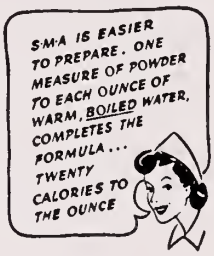
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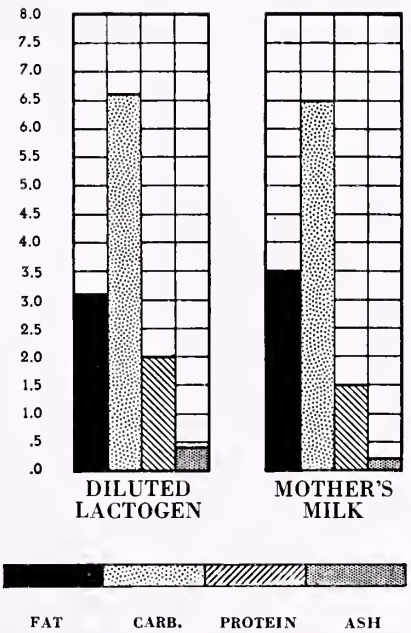




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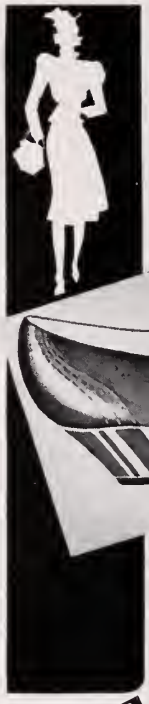
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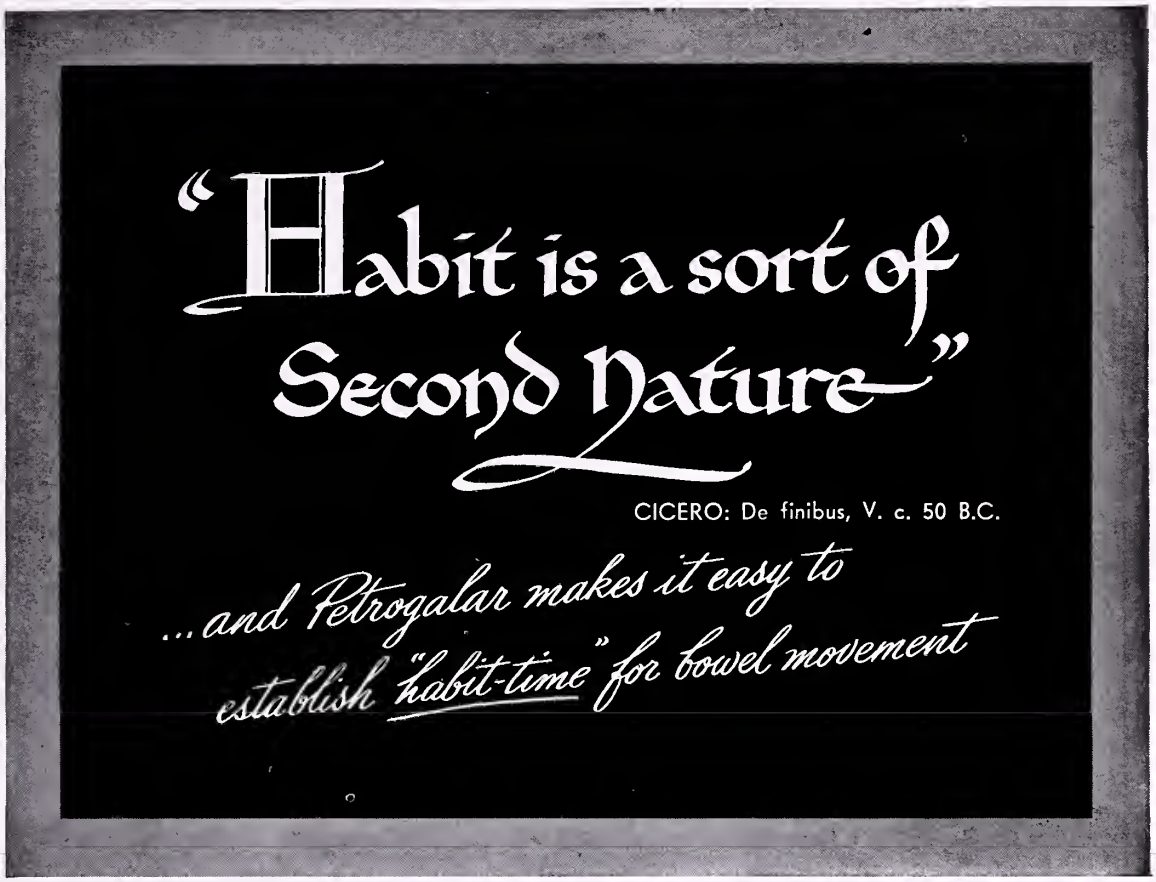
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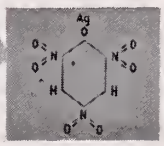
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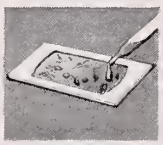
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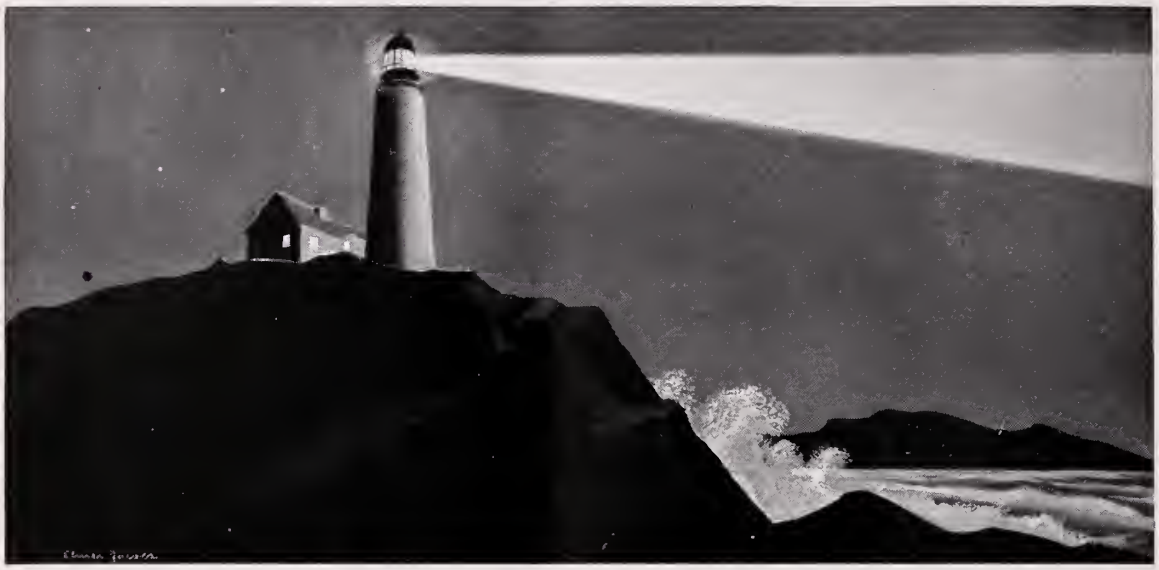
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THE RECOGNITION AND MANAGEMENT OF RHEUMATIC FEVER IN CHILDREN

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It is a real opportunity to appear before you today to speak on rheumatic fever, a disease which has become an important public health problem in our country both from the standpoint of morbidity and mortality. Consider these few figures—40,000 deaths a year with the average age of death 30 years. Besides this high mortality, rheumatic fever and rheumatic heart disease cause various degrees of physical incapacity in about 1% of the wage earning population. It is an important cause for rejection of soldiers and sailors in the armed forces, and it is expected that there will be an increase in the disease in over-crowded defense areas. Already there have been many cases in our military hospitals, especially amongst the naval personnel. In the school population it is estimated that there are about 1% of children with rheumatic heart disease, giving a total of about 200,000 so afflicted between the ages of 5 and 19. Considering all age groups, there are about 1,000,000 individuals afflicted. Mortality statistics show that rheumatic infection constitutes the major cause of death between 10 and 14 years of age, and runs a close second to tuberculosis between 15 and 24 years of age. These few figures give some idea of its importance as a public health problem.

Rheumatic fever is essentially a disease of childhood, the initial attack taking place usually between 5 and 15 years of age, with the average age of onset about 7 years. One of its chief characteristics is that it tends to recur following the initial infection, and this is the reason why it is so baffling and so unpredictable in its course. Fortunately, recurrences tend to diminish after puberty. In other words, the polycyclic types of rheumatic infection are more common before puberty and the monocyclic types after puberty. The highest mortality is in the first 5 years following the initial infection and it is therefore highly important that the frontal attack be made at this time when reactivations of the disease are so likely to occur.

In a group of 1438 children followed now for 22 years, 42% of the deaths (totaling 446) have taken place during these first 5 critical years. T. Duckett Jones has stated that of his deaths two-thirds have occurred in the first 5 years from the primary infection. It is not common for a child to die in the initial attack of rheumatic fever, but rather during a succession of recurrences. Most children who die succumb to their infection and not from congestive failure, although the latter may be superimposed. Congestive failure from rheumatic heart disease is more often encountered in adults.

In the approach to the control of rheumatic fever there are 3 cardinal principles to keep in mind:

1. Early recognition of the disease;
2. Early and prolonged treatment;
3. Prevention of recurrences.

In the early recognition and diagnosis of rheumatic fever, the burden of proof often falls on the physician. Many cases are extremely difficult to be certain about and may require months of observation. It is unnecessary to add here that accurate diagnosis is of vital import to the child and his parents and may affect his schooling and all his activities, which includes, in no small measure, his psyche. It is a humbling thought to quote Breed of Boston, in what has now almost become an aphorism, "We do not know when it starts, we often cannot recognize it when it is here, we have no cure for it and cannot tell when it is gone." But these words, written in 1932, sound worse than they are and strike too pessimistic a note. Much has been learned of the disease since that time, which gives us hope for the future.

107 EAST 85TH STREET, NEW YORK CITY
Rhode Island Medical Society, June 2, 1943

To the practicing physician and pediatrist, I wish to call attention to some of the minor patterns of rheumatic fever which may challenge us. A child about the time of the second dentition may be found by the parent or teacher at school to tire easily, to be losing weight, to have frequent nose-bleeds with increasing pallor and to complain of vague and fleeting pains in the extremities. Such a child may be found to have a slight fever, an increased heart rate, possibly an increase in the leucocyte count and probably an increased erythrocyte sedimentation rate. Other subacute and chronic infections of childhood may give similar symptoms, and our difficulty in making a diagnosis becomes apparent. At this early stage, the examination of the heart does not always help us, and although the heart is almost always involved in the rheumatic process, the valvulitis may not be clinically demonstrable until later in the course of the disease. However, the electrocardiogram may help us in the prolongation of the PR interval. Other more manifest symptoms and signs may make their appearance, such as typical multiple rheumatic joints (polyarthritis) with their extreme pain, the appearance of erythema multiforme, the finding of subcutaneous nodules, the presence of fever and tachycardia, and on examination of the heart, a gallop rhythm due to the appearance of a mid-diastolic sound, and the finding of a murmur usually systolic in time and heard best at the apex. At this stage, only time can evaluate the significance of such a murmur. All we can say is, that a carditis is probably present. It may be that a peri-cardial friction rub can be heard, which would strengthen the diagnosis of a rheumatic carditis.

The active phase of rheumatic fever may be ushered in by abdominal pain which may simulate appendicitis, and may test the acumen of the attending physician. This is a fairly frequent occurrence and has given us all concern. If in doubt, it is best to call in a good surgeon and have an exploratory laparotomy done. I have never seen such an operation do harm, and there should be no chagrin in making a wrong diagnosis. It is better to have the pathologist make a diagnosis for us in vivo, than to run the risk of over-looking an acute appendicitis with a spreading peritonitis and the death of the patient.

Chorea, which is a manifestation of the rheumatic state, may be over-looked by the physician when seen in the early stage. It is important to differentiate the irregular choreiform movements from nervous tics and habit spasms. Diagnosis is important because even mild types of chorea may be associated with severe rheumatic heart disease.

There is a common belief that rheumatism and polyarthritis are synonymous. This is not so, for the younger the child the less likely are the joints to be involved. The acutely swollen and painful joints are more often seen in the older child and young adult. I believe it is for this reason that rheumatic fever is so often missed in the very young. The presence of so-called "growing pains" have caused a misconception in the minds of many people. Their interpretation is not always easy, but it is important to differentiate between "growing pains" which are rheumatic and those which are non-rheumatic. Many children whom I have seen with carditis of severe degree have given no other history than that of "growing pains", with some of the minor patterns of the disease which I have described. Many rapidly growing children do complain of pains usually in the lower extremities at night. These are not rheumatic and in some cases can be attributed to flat feet or faulty posture. The differential diagnosis is important.

We have then, a disease which may be insidious in its onset, protean in its manifestations, polymorphic in its behavior patterns, unpredictable in its course and showing a tendency to be polycyclic. In a discussion of the management let us keep these facts in mind.

The early care of the child, that is, adequate and prolonged care following the first infection, should be stressed. In this regard, the treatment of rheumatic fever can be likened to the treatment of tuberculosis, in that it should be on a long term basis. This should be our objective and to remember that rheumatism, like the law, has a long arm. There is no reason why the child with rheumatic fever should not have as prolonged care as the child with tuberculosis.

Having instituted early and adequate care following the initial infection, the next important step in the management of the disease is the prevention of recurrences, which are more often the rule than

the exception. "Should I take my child to a tropical climate" is a question which many a parent poses to the doctor. No dogmatic answer can be given, and each case must be judged as an individual problem. The pros and the cons must be carefully weighed, for it is rarely possible to dislocate the life of an entire family, and the assurance of such a move to a southern clime cannot be stated categorically in terms of rheumatic recurrences. The question of climato-therapy, however, is rarely one to trouble the physician for the majority of our rheumatic children come from the lowest economic class and usually from homes of poverty and want. I am reminded of the adage, "If wishes were horses beggars could ride." Our problem and dilemma is not unlike that of the vitamin problem. Those who can afford them do not need them, and those who need them cannot afford them.

Barring a sojourn to the south, what then can we do to protect the rheumatic child? This becomes our main problem, and as physicians, nurses and public health workers, it is one to which we must direct ourselves. In a word, we should make every effort to protect the rheumatic child from upper respiratory infections caused by the Group A beta-hemolytic streptococcus. Such a statement is predicated upon our knowledge, almost universally accepted, that the hemolytic streptococcus, although not the cause of rheumatic fever, plays an important role in its genesis. The streptococcus may be likened to a detonator which sets off the unknown factor X resulting in rheumatic fever in the susceptible individual. It is well known that outbreaks of rheumatic fever have followed scarlet fever and streptococcal pharyngitis where large numbers of individuals are crowded together, as in barracks and boarding schools. This has been demonstrated in many of our military camps during the present war. A latent period of 7 to 21 days follows the streptococcal respiratory infection, which Coburn calls the pre-rheumatic phase and this is followed by the rheumatic phase in certain individuals susceptible to the disease. This is not unlike the invasion, latent phase and the onset of paralysis in polio-myelitis. In one child paralysis occurs, and another escapes. In one child rheumatic fever sets in, and another escapes. The immunity is largely dependent upon hereditary or acquired immune responses (or both) within the body mechanism. The child can best be protected by proper isolation in the hospital, a sanatarium or a convalescent home. If these are not possible, care can be given in a well supervised foster home. The latter is less costly and has certain advantages. In the setting up of State programs, such as you have done here in Rhode Island, I would commend to you this type of management for the rheumatic child.

In speaking of the streptococcus and its relation to the rheumatic state, a word should be mentioned concerning chemo-prophylaxis. The rationale in the use of the sulfonamides (especially sulfanilamide) has been based on the assumption that the prevention of streptococcus infection will prevent rheumatic recurrences. A number of studies have borne this out and have shown the effectiveness of this drug as a prophylactic agent. The decision to use chemo-therapy is a serious one for the drug has to be given over a period of many months. Severe toxic reactions have been encountered, and several fatalities have occurred. If sulfanilamide is used as a prophylactic, the physician should watch closely for these toxic reactions. I am sure that it is unnecessary to speak a word of caution against the use of the sulfonamides in the active phase of the rheumatic infection. They are definitely contra-indicated and usually do more harm than good. For prophylaxis they may be tried, but for therapy never, at least until our present state of knowledge is implemented by more factual clinical studies.

The word streptococcosis has been coined to express a chronic recurring infection caused by the streptococcus with a close relationship to the rheumatic state. An analogy to tuberculosis has been pointed out in the chronicity of the two diseases and their widespread dissemination throughout the body. The newer concept of rheumatic fever is that it is a systemic disease affecting many organs and tissues. The heart is the organ which, by its involvement, does affect the ultimate prognosis and the severity of the repetitive attacks of rheumatic fever, causing increasing cardiac damage, is the chief feature controlling the immediate outlook. Carditis, then, is the chief visceral manifestation of rheumatic fever and makes the disease the serious one it is.

As in tuberculosis, the best treatment for rheumatic carditis is complete rest in bed during the acute and sub-acute stage of the disease. Consider what bed-rest does for a child suffering from rheu-

matic heart disease, who has a tachycardia of say 120 beats per minute. If the heart can be slowed only 10 beats per minute by bed-rest, this means that in 24 hours it contracts nearly 15,000 less times. This, in itself, is a conserving process in a vital organ, which is so seriously affected by the rheumatic infection. Prolonged rest should therefore be continued until the active rheumatic infection has become quiescent.

An active educational program on rheumatic fever has been recently launched in this country. Your State is taking an active part, and has been forward looking in that the disease is now reportable. In such a campaign stress is put on early and exact diagnosis. As physicians we should exercise every care before we label a child as a cardiac. Too many children are being taken care of in heart clinics or by private physicians without justification. They have been condemned for years to a life of partial invalidism merely because of a heart murmur. This is indefensible. It is all too easy to develop an "invalid reaction" in these children. They grow up with feelings of insecurity, inferiority and anxiety states, and make up in adult life the group of so-called "cardiac neuroses". This, then, is the other side of the picture, and is included in this presentation merely as a plea for exact diagnosis. I would suggest that consultative cardiac clinics be set up, to which physicians can refer their patients for diagnosis, when they are in doubt or need the added aids which the X-ray, fluorescope, electro-cardiogram, sedimentation rate can give.

The care of the rheumatic cardiac child involves problems in education, in occupational therapy and in vocational guidance. Time does not permit to do more than mention these as an important part of the total program. We should always keep in mind that there is not only the heart to be treated, but there is the child who has the heart. We must not think of him as crippled but merely as handicapped. In his rehabilitation the public health nurse, the Social Service worker, the teacher and the occupational therapist play a large part.

In conclusion, I hope I have given you some conception of the size and importance of rheumatic fever as a public health problem. Rhode Island is one of 13 states which have set up State programs for the care of these children and young adults up to 21 years of age, and 5 other States have made application to the Children's Bureau. With the increasing dissemination of knowledge it is hoped that physicians, nurses, parents, teachers and all who have anything to do with children will have more of an awareness of rheumatic fever and will regard it as one of the most serious diseases of childhood.

EXTRAPERITONEAL CECOSTOMY

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The history of decompression of the obstructed colon has been one of slow and steady progress. Littrè in 1710 was the first to suggest and describe an intraperitoneal cecostomy. Pillore of Rouen, in 1776, performed this operation for the first time, through a McBurney incision and the opened cecum was sutured to the skin in this case. Duret in 1793 performed the first extraperitoneal colostomy. Callisen of Copenhagen in 1800 and then Amussat of Paris, championed and popularized extraperitoneal colostomy. The incision invariably was in the left lumbar region.

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With the advent of asepsis and anesthesia, the intra-abdominal procedure of Littrè came back into prominence and the extraperitoneal technique faded into obscurity. Many modifications have been advocated, each a definite improvement on its predecessor. The indications for a cecostomy, a transverse colostomy or a sigmoidostomy have become definitely established. The necessity for a temporary or permanent artificial anus likewise is well understood.

A simple extraperitoneal cecostomy can be performed as follows: A McBurney, gridiron incision

is made. It is wise to place the incision closer to the anterior-superior spine and slightly higher than the usual appendix incision. The external oblique fascia (and muscle, if one is that high) is cut obliquely. The internal oblique and the transversalis muscle are split transversely so as to expose the peritoneum. In the cases of acute obstruction of the left colon, with distention of the cecum, one finds that the reflection of the peritoneum over the cecum and onto the posterolateral abdominal wall, is elevated. That is, the peritoneal angle in the right lateral gutter, rises with the increasing distention of the cecum, thus increasing the area of unperitonealized cecum and ascending colon. This fact is taken advantage of in the next step of the operation.

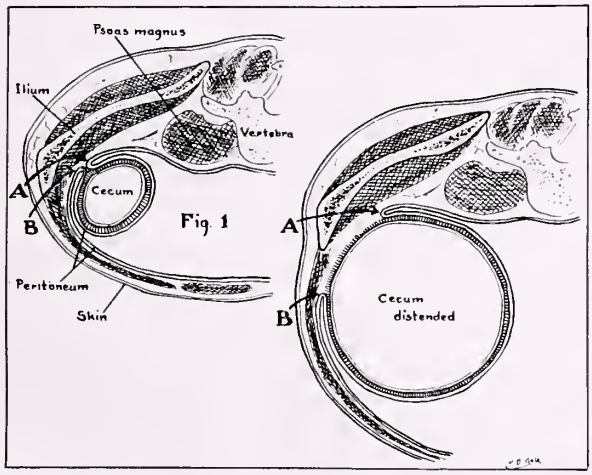


FIG. 1. Diagram demonstrates the increase in the unperitonealized portion of cecum present in cases with marked distention. See A-B. The reflection of the peritoneum at B can frequently be "elevated". Cecal wall can easily be brought up to skin level. See picture No. 2.

The peritoneum is pushed up and towards the midline so as to expose the posterior surface of the cecum or if need be, the ascending colon. This portion of the bowel is grasped with Babcock clamps, the bowel is further mobilized by finger dissection and can ordinarily be brought up to the skin level. Purse-string sutures are placed and the bowel is opened. A trochar is preferable, as it allows one to drain off the distended bowel without covering his field with feces. A larger catheter is then inserted and the purse-string suture is tied. A cigarette drain is inserted down to this region and sulfanilamide powder is sprinkled freely into the wound. The wound is then sutured loosely. If a small incision has been made, only one or two sutures are necessary. In our second case no sutures were used.

The placing of two Kocher clamps, as now practiced by Dr. Cattell, above and below the catheter so that each clamp catches about ¼ inch of the cecum, closest to the opening, is helpful, in that when the clamps are flattened down on the abdominal wall, they serve to prevent retraction of the cecum, when the bowel has been decompressed. They also destroy, by crushing, a little more of bowel wall, so that when the clamps and tube are removed after 72 hours, a good large opening in the cecum is obtained.



FIG. 2. Photograph of a patient. Note how clamps keep cecum on a level with skin. Drains can be seen below lower clamp. Note also size of incision and absence of sutures.

If one should discover at operation that the posterior surface of the cecum cannot be exposed because of the fixation of the lateral peritoneal reflection, then a two-stage transpertioneal procedure, such as has been advocated for drainage of appendiceal abscesses, can be used. That is, as soon as the peritoneum has been exposed, it is packed

against the lateral cecal wall with dry or vaseline gauze. After a suitable time interval, preferably 24 hours or more, the opening into the bowel can be made with a trochar and the catheter, etc., inserted.

In all cases of this type, a Miller-Abbott tube can be used in conjunction with the cecostomy. This is especially necessary in those cases in which a delayed type of operation is to be performed.



Fig. 3. Photograph at autopsy. Right anterior abdominal wall has been rolled out. The posterior peritoneum has been incised exposing retroperitoneal area. Thumb forceps hold one edge and clamp is placed on other edge. Cecostomy opening can be seen between the two margins of the incised postero-lateral peritoneal reflection.

Cecostomy, as a palliative operation preceding left colonic surgery, is often a life-saving measure. This is especially true in those first seen with marked obstruction. The intraperitoneal operation presents few technical difficulties, but a review of the results obtained in those cases that are first seen acutely obstructed and markedly distended, reveals an unusually high mortality rate, which is ordinarily attributed to the poor condition of the patient.

A critical review of the intraperitoneal procedure, however, would lead one to suspect that peritonitis, rather than the patient's condition, is the real offender. Contamination of the peritoneal cavity is inevitable, whether one uses a needle to deflate the distended cecum, purse-string sutures about a catheter, a trochar or a suction tube. Spillage about these, varies with the degree of bowel distention, the fluidity of the bowel contents, or the ease with which one introduces the catheter into the bowel lumen. Some leakage, no doubt, also occurs within the first 24 hours postoperatively, even though the catheter is brought through a hole in the omentum. Many will say that this contamination is insignificant, that the peritoneum is well able to take care of it or that the sulfa drugs will prevent peritonitis. These factors are a Godsend in the young, healthy and unobstructed patient but are they of as much help in a patient who has cancer, who has been obstructed for days, who is dehydrated and has a low serum protein as well as avitaminosis? This type of patient will not tolerate contamination of his peritoneal cavity and moreover will react unfavorably to anything except a minimal amount of handling.

Extraperitoneal cecostomy offers us an opportunity to decompress the bowel with no fear of peritonitis and with no possibility of handling or fighting the distended loops of small bowel, which invariably, when one uses a right rectus or McBurney incision, have to be walled off.

Some may fear an ascending infection in the retrocolic area and because of this, object to the extraperitoneal procedure. We have had no trouble with infection and feel that infection will usually take the path of least resistance. Thus if the region is packed with two to five grams of sulfanilamide or microcrystals of sulfathiazole and drained, the infection should remain well localized. Retrocecal appendiceal abscesses are often drained by this same procedure with no fear and rarely with any complications. It is considered as an ideal approach in these cases, by many surgeons.

Extraperitoneal cecostomy, because of this, is a safe procedure. Another distinct advantage is that we work in a virgin peritoneal cavity during the second stage. It is very simple and can be performed in much less time than the intraperitoneal operation. The operating time in our four cases has averaged twenty minutes, and all of our cases were carried out under local anesthesia.

It is wise preoperatively to take a flat plate of the abdomen in order, if possible, to locate the cecum. This will save embarrassment if one should encounter a high cecum.

The following four cases, each performed by a different surgeon, present many interesting facts. First let us consider the simplicity of the technique. The idea occurred to me while our surgical service was discussing the treatment of our first patient whom we believed would die if operated upon. Surprisingly, the operation was completed in twenty minutes and most of the time was spent collecting the feces, which exploded out of the cecostomy into a large basin.

The second case was operated upon by Dr. A. Eckstein, while I was standing by. He completed his operation in twenty minutes.

The third case was performed by Dr. O. Smith, who assisted me on the first patient. He encountered no difficulty.

The fourth patient was operated upon by Dr. E. Porter. I assisted at this operation and no complications developed. No case showed any signs of an ascending retrocolic infection.

In all these cases, the unperitonealized portion of the cecum was easily brought up to the skin margin and held there by clamps, even though several of the men had never seen the operation performed.

Three of these patients lived. The fourth one died twelve hours postoperatively. The cause of death as revealed by autopsy was a volvulus of an unusually large sigmoid with secondary thrombosis of the involved mesentery and gangrene of the bowel.

The three patients that lived were operated upon again. In all of these as well as in the patient that died, it was established that the peritoneal cavity was not entered into during the cecostomy operation, thus giving the surgeon the benefit of a virgin peritoneal cavity.

In my patient, I was able to resect a carcinoma of the midsigmoid and do an aseptic end-to-end anastomosis. This patient is living and well, seven months after his operation. The cecostomy closed spontaneously.

Dr. Porter's patient was found to have many metastatic lesions in the liver and glands and a carcinoma of the rectosigmoid. A loop sigmoidostomy was performed.

Dr. Eckstein's case is the only one in which the distention was not relieved. It was then realized that the obstruction was proximal to the cecum even though the original flat plates of the abdomen showed marked distention of the colon down to the sigmoid. At a second operation, exploration revealed metastatic lesions obstructing the small bowel. An ileostomy was performed. The progress was steadily downhill, and the patient died four weeks after admission.

These cases bring out the one fault of an extraperitoneal cecostomy. That is, its failure to allow an inspection of the abdomen and it is for that very reason that its use should be limited to those neglected cases that come into the hospital markedly distended and toxic. Here one cannot waste too much time with the Miller-Abbott tube and the usual cecostomy will not be tolerated. We feel that in these cases an extraperitoneal cecostomy is of distinct advantage.

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LEUCOPENIA IN INFECTIONS

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Leukopenia exists if the white cells in the circulating blood are definitely below their normal range of from five to ten thousand. Four thousand is the commonly accepted figure below which it is present.

We usually think that leukopenia is due to the decreased production of white cells, and this is no doubt the commonest and most important cause. There are, however, other possible mechanisms. Lawrence has divided them into five groups, the first of which is diminished production, and this group is again divided into four sub-groups. The first of these is a simple inhibition of the bone marrow, and this is the method by which leukopenia is commonly produced in infections. The second subgroup is the so-called maturation arrest, a process that occurs in at least some cases of agranulocytosis. The third is marked by aplasia of the bone marrow, as in aplastic anemia, and the fourth is due to infiltration of the bone marrow, as in tubercular disease affecting the bone marrow, or metastatic malignancy invading it, and crowding it enough to interfere with its function. Lawrence's second main group is increased leukocyte loss, as may occur with large purulent exudates in empyema, peritonitis or ulcerative colitis. The third is accelerated cell destruction in the circulating blood—this supposes the formation of a leukocytic toxin by infection or other pathological process. The fourth group is redistribution of the cells in the vascular channels, as occurs after the injection of a foreign protein, as typhoid vaccine, or after an allergic reaction. The cells are sequestrated in the internal organs—the liver, lungs, etc.—where they are commonly stored, and decrease in the peripheral blood. This is an interesting but temporary and unimportant process. The last group is that of redistribution of the cells in the body as a whole—the method in subleukemic leukemia, when there is leukopenia with infiltration of the body tissues with quantities of white cells.

As has been said, the main method of development of leukopenia in infection is the simple inhibition of the bone marrow. This is by some unknown toxin produced in certain infections. The mechanism may be simple or it may be covered with a cloak of simplicity that has as yet not been removed. The white cells are developed in the bone marrow in an orderly but retarded fashion. This process differs from that in some cases, at least, of agranulocytosis, where the development of the cells proceeds to the final stage of maturation but stops there. These cells, failing of complete maturation, are not released into the blood stream, and increase in the marrow. In infectious leukopenia, however, each step of development is carried out, but in a leisurely manner.

The infections which typically produce leukopenia are well known. There are certain bacteria, those of typhoid, the para-typhoid group, and tuberculosis. A few protozoal infections also are included, malaria being the only one of any consequence here, with Kala-azar and relapsing fever in the list. Virus infections that cause it are those of measles, German measles, and influenza. In addition there are other virus infections that are usually characterized by an initial leukopenia which is succeeded by a leukocytosis—these are smallpox, the virus pneumonitis which has been increasingly prevalent of late years, and infectious mononucleosis. In the hospital we usually find that our virus pneumonitis cases have a normal or slightly elevated white count—if the count is more than moderately elevated we are inclined to look for secondary or intercurrent infection or to question our diagnosis. Less than half of these cases show leukopenia. Probably if we had these cases at the onset and not after a week or so of their course, as we commonly do, we would have a higher incidence of leukopenia. As to mononucleosis, I think it is generally considered to be characterized by a moderate leukocytosis. The figures of a series of cases rather recently reported show, however, that a third of them never have a white count above ten thousand and that more than half have a definite leukopenia during the first week. In a condition which may have as varied manifestations as this one, this fact may well be borne in mind. Recently we had a case on the service with a high tempera-

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ture, no glandular enlargement and a leukopenia. Mononucleosis was not considered until it was suggested to us, in Saturday conference, by Dr. Fox. This diagnosis was confirmed—if we had been more aware of the frequency of the initial leukopenia we would probably not have missed it.

Leukopenia occasionally occurs in an infection in which leukocytosis is expected, and may have different implications. A case of pneumococcic pneumonia, say, has a low white count. His temperature is low, he is not toxic, and we assume that he has a mild infection which is being handled in stride. The bone marrow has not been markedly stimulated as there is no need to call out the reserves to handle the situation. We consider the prognosis to be good. A similar pneumonia with the same count is toxic, has high temperature, etc.—in his case we think that the bone marrow has not been stimulated but overwhelmed by a severe infection, and is unable to meet the call for increased white cells. We consider the prognosis in this case to be poor, especially if in addition to his low count there is an increase in the younger leukocytic forms—the nonfilamented ones—above their normal six per cent, and the smear shows the toxic granulizations and vacuolization of the cytoplasm that go with severe bone marrow effort.

A factor that may modify the leukocytic reaction is the location in the body of the infection. For instance, pulmonary tuberculosis commonly evokes a leukopenia, but in tubercular meningitis leukocytosis is the rule.

The inhibitory effect of infection on bone marrow is not usually an absolute one. If intercurrent pyogenic infections develop—as a bronchitis in the course of typhoid—there will be the usual leukocytosis, which will last until the bronchitis has cleared, and will then be replaced by leukopenia if the typhoid is still active. Zondek has recently reported similar white cell response, in typhoid, to certain bone marrow stimulating chemicals with which he has been working. In neither case has the typhoid be benefited by the leukocytosis.

THE AMERICAN CONGRESS OF PHYSICAL THERAPY

Will hold its twenty-second annual scientific and clinical session September 8, 9, 10 and 11, 1943, inclusive, at the Palmer House, Chicago. Rehabilitation is in the spotlight today—Physical Therapy plays an important part in this work. The annual instruction course will be held from 8:00 to 10:30 A.M., and from 1:00 to 2:00 P.M. during the days of September 8, 9 and 10, and will include a round table discussion group from 9:00 to 10:30 A.M., Thursday, September 9. The scientific and clinical sessions will be given on the remaining portions of these days and evenings. A feature will be an hour demonstration showing technic from 5:00 to 6:00 P.M. during the days of September 8, 9 and 10. All of these sessions will be open to the members of the regular medical profession and their qualified aids. For information concerning the instruction course and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.



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DR. CHARLES F. GORMLY

On June 26th Dr. Charles F. Gormly died. The factual story of his career is given in the address by Dr. Hammond, published in the June issue of this JOURNAL. The value of his life to his friends and colleagues, to his casual acquaintances, indeed to every citizen of Rhode Island, is beyond our ability to estimate.

Throughout the thirty-one years of his active practice he has always been a dynamic force for the betterment of the condition of his patients, his medical associates, his hospital and his community. Up to the very time of his death he preserved a cheerful optimism and a clear-sighted interest in the planning of a future in which he knew he could not share.

Always, even in the face of inevitable physical suffering and disaster his ready wit and glowing humor never failed. For almost a year and a half, as was generally known, he suffered the progressive inroads of an incurable malady and yet he carried on undaunted as practitioner, consultant and physician-in-chief and in addition brought to a most successful conclusion his year as President of the Rhode Island Medical Society.

The courage with which he fought this campaign through equals the most heroic deeds for which men are decorated on the field of battle. He is a life-long inspiration to us all.

REORGANIZATION

With the next number of this JOURNAL Mr. John E. Farrell, now Executive Secretary of the Rhode Island Medical Society, will take over his duties as Managing Editor. His brilliant brain child, the *Providence Medical News,* will cease to exist in its present being, but by a happy metempsychosis will continue to flourish in our columns.

It was unique in its concept and development and has been flattered by numerous imitators. All the interesting and important subject matters of news, economic and sociological value that Mr. Farrell has so brilliantly found, recognized and presented will appear in a new setting. As a part of our old and honored Medical Society it should have even wider fields for progress.

The Society has grown not only in membership during late years but has shown a new liveliness and power. The local Association with its frequent meetings had, even before the reorganization of a few years ago, developed an initiative in supplying the needs of a major portion of the profession in the state. This had reacted unfavorably on the parent group, which is now coming into its own again. It is going to need a better journal with a broader scope. The teamwork will undoubtedly be mutually helpful.

The News was a development of the notices of meetings by the Providence Association. The JOURNAL will take over this duty and therefore will be published in the last week of each month. At present, due to war conditions, (the facile explanation of any failure to function properly) the JOURNAL is behind its publication schedule. This will be made up during the summer, and in the fall when meetings are renewed, it will perforce appear at the proper time.

The present editorial board is composed largely of members in the armed forces. Hence there will be a readjustment. To those who have served us in the past our thanks are given and when better times arrive we may ask for their help again.

With Mr. Farrell's great business ability, energy and flair for correlating our diverse interests we confidently predict a pleasing future.



PRESIDENT MICHAEL H. SULLIVAN

We congratulate Dr. Michael H. Sullivan on his accession to the Presidency of the Rhode Island Medical Society.

It is fifteen years since Newport was thus represented by Dr. Norman MacLeod, who filled the office so efficiently in those happy days of long ago.

Two centuries or so back Newport was the great seaport of the country, and Providence just an up the bay place that some of the smaller craft could reach. Then, as a number of historical articles in the JOURNAL have made clear, the same proportion held in medical matters. But manufactures and commerce have made Providence big and the overwhelming number of physicians have congregated here. Hence it is only rarely we now get our leader from the Island of Aquidneck.

Dr. Sullivan is the dynamic type to which we are accustomed in our Presidency. Almost at the beginning of his career he had a tremendous obstetrical practice in addition to his other work. He has served on the Board of Health over twenty years and is now vice-president; in both wars he has been active in the draft work.

He has been president of the Newport Medical Society and the staff of the Newport Hospital. With many years on the surgical staff he became chief of the obstetrical service when that was organized.

With all this experience he is well equipped to lead our organization and we predict a good and interesting year under him.

NICHOLAUS COPERNICUS, PHYSICIAN

Four hundred years ago, in 1543, appeared two immortal books. In May of that year an old man, about to die, held before his dimming eyes the first copy of *De Revolutionibus Orbium Coelestium*. He was Nicholaus Copernicus. In June of that same year a young man gave to the world *De Fabrica Humani Corporis*. He was Andreas Vesalius. Thus were born within one month of each other modern astronomy and modern anatomy, both of them the offspring of physicians.

Nicholaus Copernicus was born in Poland on February 19, 1473, and spent his childhood in his native town. When his father died he was placed under the guardianship of his maternal uncle, a man of distinction who was later a bishop and Polish Senator. Under the tutelage of his uncle the young Copernicus prepared himself for the pursuit of higher studies and from 1491 to 1495 he was a student at the ancient Polish University of Krakow which for the first time in 575 years has been closed by the Nazi barbarians. While studying at the University two things happened to Copernicus which influenced greatly his future interests and studies.

He came under the spell of the brilliant humanist astronomer and mathematician Albert Bruzewski, who was undoubtedly the first to arouse in his young student a love for the ancient science of astronomy. The second determining event in Copernicus' intellectual life was the arrival at the University of four astronomical instruments. As Dr. Stephen C. Mizwa informs us these were brought from Buda, Hungary as gifts to the University of Krakow. There was a large celestial globe, two beautiful astrolabes and a triquetrum. The arrival of these instruments created such a sensation that the Rector called a special student assembly to behold and admire these wonders. They have been preserved by the University to this day, and we may be sure that Copernicus was one of the most interested spectators.

For further study Copernicus journeyed to Italy which then was for earnest students sancta mater studiorum. At Bologna he enrolled as a student of canon law which in those days was essential to the training of a prospective Churchman. In 1500 we find him in Rome lecturing on mathematics and astronomy. From 1501 to 1503 he studied medicine at the University of Padua and at the same time obtained a doctor's degree in canon law at Ferrara.

Enriched with multifarious learning he returned to Poland and entered upon his duties as canon of the duchy-bishopric of Varmia. He was occupied with many things, acting as physician and secretary to his uncle Bishop Lucas, devoting much time to the healing of the sick-poor, continuing his astronomical observations and taking an active part in the politics of the day. It was in Varmia that Copernicus pursued his astronomical studies and tabulated the immense collection of data which culminated in *De Revolutionibus*, and it was there that he died on May 24, 1543.

To-day the ancient Polish people are being exterminated by the sub-bestial savagery of the German invader just as their forebears were harassed by the Teutonic Knights in the lifetime of Copernicus. But in spite of the darkness which covers their land, Copernicus still stands before his desolate countrymen as a star of hope and an incentive to endure. When the Germans entered Poland in 1939 they announced that they would make a "cultural wilderness" out of the land they conquered. They have done their best to make good their promise before a shocked and outraged world. And although the memory of Copernicus may not be publicly honored in his native land, it is heartening to know that here in America the Copernican Quadricentennial National Committee composed of distinguished scientists, scholars and educators has been devoting itself to the furtherance of commemorative exercises in honor of the great astronomer. And we physicians should be, as indeed we are, pleased to join in this expression of esteem for one of our profession, since Copernicus is worthy of remembrance not as a great astronomer only but also as a humble physician, a medical alumnus of "fair Padua", the prolific mother of Linacre, Vesalius and Harvey.

JOHN E. DONLEY, M.D.

RHODE ISLAND MEDICAL SOCIETY

REPORT OF THE COMMITTEE ON EDUCATION: STATE AND NATIONAL

Herewith is submitted the report of the Committee on Education of the Rhode Island Medical Society for the year commencing June 1, 1942.

The fifteen-minute radio talks which have now been running continuously since December 1938, over Station WPRO every Sunday afternoon at 1:30 P. M., have been continued without letup, and it is apparent from the many letters and requests for copies of talks that our audience is a growing and enthusiastic one. Forty-six radio talks have been given in the past year.

1,015 letters have been received by your committee this year from the general public requesting copies of these talks, and this same number have been mimeographed and mailed to the radio audience. There are six who call for a copy of each lecture. This regular mailing list includes Miss MacDonald at the Public Health Library, Miss Carberry of the Rhode Island State Department of Social Welfare and Mr. Dunham from the Red Cross. Many of the letters received contain not only requests but expressions of appreciation.

It is the belief of your committee that these radio talks should again be continued as in the past. We wish to express our thanks to Miss Dickerman and her associates and to Mr. John Farrell, Executive Secretary of the Providence District Society, for the work and assistance which they have rendered to the committee. We wish also to express our thanks to Station WPRO for its courtesy in giving us time, to Blanding & Blanding, Inc., for the advertising which has been freely contributed, and to the many members of the profession who have by their cooperation and suggestions been of invaluable aid.

Respectfully submitted,
JESSE P. EDDY, 3RD., M.D., *Chairman*

COMMITTEE ON NECROLOGY

Your Committee on Necrology herewith submits its report of deaths of members of this Society which have occurred during the past year:

Frederick N. Brown, M.D., Providence. Died May 23, 1942.

F. Edward Burke, M.D., Wakefield. Died October 21, 1942.

John P. Cooney, M.D., Providence. Died January 15, 1943.

Preston D. Geiger, M.D., Providence. Died October 24, 1942.

Henry W. Hopkins, M.D., Warren. Died October 14, 1942.

Patrick H. Keefe, M.D., Providence. Died June 4, 1942.

Thomas F. Kennedy, M.D., Woonsocket. Died March 10, 1943.

Captain Thomas A. Martin, MC, AUS, Providence. Died August 4, 1942.

Ardashes H. Merdinyan, M.D., Pawtucket. Died November 26, 1942.

Charles B. O'Rourke, M.D., East Providence. Died February 13, 1943.

Charles N. Raymond, M.D., Providence. Died September 19, 1942.

Charles W. Stewart, M.D., Newport. Died March 26, 1943.

Charles A. Sylvia, M.D., Providence. Died November 12, 1942.

Respectfully submitted,
EDWARD T. STREKER, M.D., *Chairman*

REPORT OF THE COMMITTEE ON THE LIBRARY

Because of prevailing conditions the activities of the Library have somewhat changed during the past year. Many of the Fellows who were among the most regular users of the books and periodicals have left for service in the various branches of the armed forces. On the other hand, the Library has been consulted constantly by officers who are stationed in this state and in Connecticut. Early last year it was deemed proper and fitting to extend the privileges of the Library, with certain restrictions, to all such officers, and the result has been that the Library personnel has been able to answer many inquiries, and to do much reference work by telephone.

The total number of visitors at the Library has been less than for some years, but there has been a corresponding increase in the number of consultations by telephone.

Statistics for the year:

Number of visitors	1,411
Journals bound	95
Journals repaired	4
Books received, through purchase, gifts and from the R. I. MEDICAL JOURNAL, sent for review	96
Journals received, by subscription, and exchange for the R. I. MEDICAL JOURNAL	132
Number of books in the Library, April 18, 1943	33,168
Books and Journals catalogued to April 18, 1943	21,073

Gifts from Fellows:

Dr. H. H. Armington ..... 15 volumes
Dr. R. S. Wilcox ..... 5 volumes
Journals from Drs. J. E. Mowry, R. Hammond, F. V. Corrigan and L. I. Kramer.

Circulation: 335 Journals and 120 books
Interlibrary loan requests, 9.

Respectfully submitted,
HERBERT G. PARTRIDGE, *Chairman.*

REPORT OF THE CHAIRMAN OF THE BOARD OF TRUSTEES OF THE RHODE ISLAND MEDICAL SOCIETY BUILDING

April 17, 1942 — April 22, 1943

Number of meetings held in the building, 48; inclusive of meetings of the Providence Medical Association. Also, two outside organizations held meetings in the R. I. Medical Society Building. This is the smallest number of meetings for which we have received donations in any one year.

The Rhode Island Recruiting Board of the Procurement and Assignment Division of the U. S. Army was granted the temporary use of the building from May 1942 to October 21, 1942.

The outside of the building has been painted and all the screens have been repaired and painted apart from other minor repairs.

Respectfully submitted,

ELIHU S. WING, *Chairman*

REPORT OF THE TRUSTEES OF THE FISKE FUND

At the present time, the moneys left by Dr. Caleb Fiske to encourage original work on the part of the members of this Society, amount to a little over $12,000. These funds are invested by court order in such a way that the income, under present conditions, is almost negligible; in fact, it is so small that the Trustees have felt unable to offer any premium this year, or to carry on any of the normal activities of the Fund. They are making efforts, however, to have the investments changed in such a way as to bring about a reasonable return, and they hope to be able to continue the work of the Fund next year.

Respectfully submitted for the Trustees,

WILFRED PICKLES, M.D., *Secretary*

BOOK REVIEWS

A MANUAL OF CLINICAL THERAPEUTICS (A Guide for Students and Practitioners), xv 609 pp. By Windsor C. Cutting, M.D., Associate Professor of Therapeutics, Stanford University School of Medicine. W. B. Saunders Company, 1943.

To encompass the entire field of therapeutic knowledge into one brief volume is a vast undertaking, yet that task is attempted in this fairly small and short book. The material is organized in the usual fashion — infections and infestations, virus diseases, endocrine and metabolic disturbances, allergy, physical phenomena, and finally groups of disease entities associated with various body systems. To this text is added in appendiceal form data on therapeutic procedures, physiotherapy, poisonings, diatetics, prescription writing and drugs, normal values, and common laboratory methods for controlling and estimating dosage.

When the author chose the name clinical therapeutics, he did not mean that this was to be a work on pharmacology, but to include general advice, physiotherapy, and psychotherapy. Indeed the scope of the book is so broad that there is a rather sketchy treatment of many subjects, particularly in the management of tropical and verminal infections and infestations, and diseases associated with the gastro-intestinal tract. Likewise the work suffers from the inclusion of rather rare and fancy conditions in occasional instances, many of these of a surgical nature, e. g. thrombosis of the superior mesenteric artery.

On the positive side of the ledger there is an admirable restraint exercised by Dr. Cutting in the choice of drugs and pharmaceutical agents, and as one reads there approaches a feeling of confidence that results can be expected where they are promised. There are several simple prescriptions included, and values are given in both metric and Latin systems. The author feels that the metric system should be universally adopted, and uses simple English for his directions. The recommendations for the use of sulfonamides are very circumspect. References to the periodical literature which is usually readily available and which appear after each small section would appear to be a thoughtful and helpful feature. On the whole the compilations of data in the appendices are more useful than the text itself, and add greatly to the value of the book.

HAROLD S. BARRETT, M.D.

NEUROSURGERY AND THORACIC SURGERY by National Research Council. W. B. Saunders Company.

This volume is prepared by the subcommittees on neurosurgery and thoracic surgery of the National Research Council.

Two-thirds of the manual are devoted to neurosurgery. Although it is written primarily to give military personnel established methods of treatment in gunshot wounds of the brain, spinal cord and peripheral nerves, it contains much information on treatment of traumatic neurosurgical cases of civilian life.

The chapter on Gunshot and Other Injuries of Scalp, Skull and Brain by Drs. Gilbert Horrax and Claude Coleman is admirably written, detailing in very simple terminology the early treatment of head injuries.

The remaining one-third of the manual is devoted to thoracic surgery. It is designed primarily to increase the accuracy of diagnosis within the combat zone with prompt first aid control of the complications of chest wounds.

DANIEL V. TROPPOLI, M.D.

PRINCIPLES AND PRACTICE OF OBSTETRICS by Joseph B. DeLee — J. P. Greenhill. W. B. Saunders Co. 1943.

This eighth edition of DeLee's textbook is published five years after the last, and less than a year following the death of the senior author. Doctor Greenhill, who rearranged the book, rewriting and adding new material, is an eminent gynecologist and obstetrician, long associated with Doctor DeLee.

This work has been brought up to date in many details. Significant additions, reflecting current research, concern such subjects as caudal anaesthesia; roentgen pelvimetry and the newer classification of pelves; the Rh factor and its relation to erythroblastosis; chemotherapy in puerperal infections; and the new Waters type of extraperitoneal Cesarean section. A concise chapter on Endocrinology, further elucidation of the physiology of uterine activity, and an exposition of the most recent approach to the problem of the toxemias, round out this very complete text.

CHARLES POTTER, M.D.

MORE HELP FOR MILK-ALLERGIC PATIENTS

Appetizing and nutritious recipes for using Mull-Soy in milk-free diets are now available in a new publication of Borden's Prescription Products Division. Already widely prescribed as a hypoallergenic substitute for milk in infant formulas, Mull-Soy is now proving equally useful in diets of older infants, children and adults who are allergic to milk.

Mull-Soy is an ethically-marketed soybean food in liquid emulsified form. It is palatable, readily digestible, well-tolerated, and easy to use. Although hypoallergenic in most cases of milk allergy, it nevertheless closely resembles milk in nutritional values of protein, fat, carbohydrate, and minerals. Mull-Soy ingredients are entirely of non-animal origin, consisting of soybean flour, soybean oil, soybean lecithin, dextrose, sucrose, calcium phosphate, calcium carbonate, salt, and water. After special processing at carefully controlled temperatures, the mixture is homogenized at high pressure, sealed in sanitary-type cans, and sterilized. In flavor it is slightly sweet and nutlike, and many find it makes a pleasing warm drink when simply diluted with an equal amount of hot water.

Included in the new Mull-Soy recipe folder are numerous beverages, soups, and desserts, as well as directions for using Mull-Soy in place of milk or cream for cereals, coffee, mashed potatoes, etc. Each recipe has been carefully tested in the Borden Experimental Kitchen and checked for palatability, ease of preparation, and suitability for milk-free allergy diets. A number of the recipes have several suggested variations and optional ingredients which permit greater variety in the diet and also make the

recipes more useful for patients allergic to other foods in addition to milk.

These Mull-Soy recipe folders are designed for distribution by physicians to their patients. Any desired number of copies may be obtained by writing to Borden's Prescription Products Division, Department CB, 350 Madison Avenue, New York 17, N. Y.

CHANGE IN CASEC MEASUREMENTS

Casec now measures six *packed* level tablespoonfuls instead of 12 level tablespoonfuls as formerly, so that directions to the patient should be amended accordingly. Casec is indicated in colic and loose stools in breast-fed infants, and in fermentative diarrhea, malnutrition, celiac disease and for premature infants. Mead Johnson & Company, Evansville, Indiana, U.S.A.

TETANUS IMMUNIZATION OF MILITARY PERSONNEL

All military personnel on induction are being immunized against tetanus either, as in the Army, by three injections of fluid toxoid, or as in the Navy and Marine Corps, by two injections of alum precipitated toxoid (New Eng. J. Med., 227:162, 1942). In addition a small or stimulating dose is injected prior to departure for a theater of operations and an emergency dose is given to those wounded or burned in battle or incurring other wounds likely to be contaminated with *Clostridium tetani*. According to recent report (Am. J. Pub. Health, 33:53, 1943) since June, 1941, when the present tetanus immunization program was adopted, there have been but four cases reported from the entire Army, and none of these were in immunized individuals. Although perhaps too early in the present war to draw any conclusions, it is of particular interest that no cases of tetanus have been reported from battle casualties.

For civilian use, especially in children, it is of decided advantage to accomplish simultaneous immunization against tetanus and diphtheria. Combined Diphtheria Toxoid-Tetanus Toxid, Alum Precipitated, Lilly, is designed for prophylaxis only, affords effective immunity against both diseases, and avoids risk of serum sensitization which may follow use of an antitoxin.

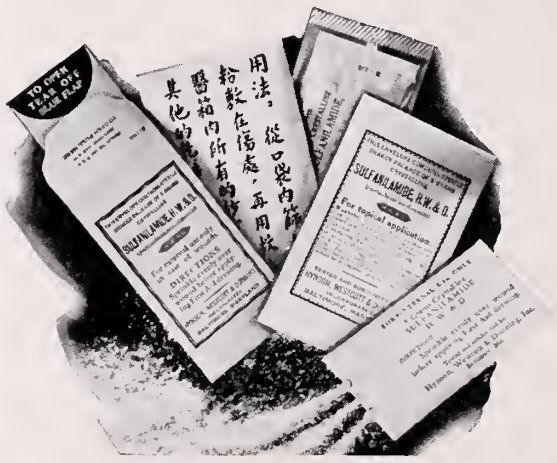
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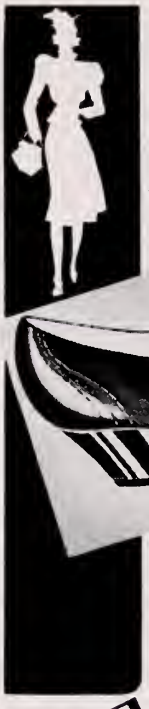
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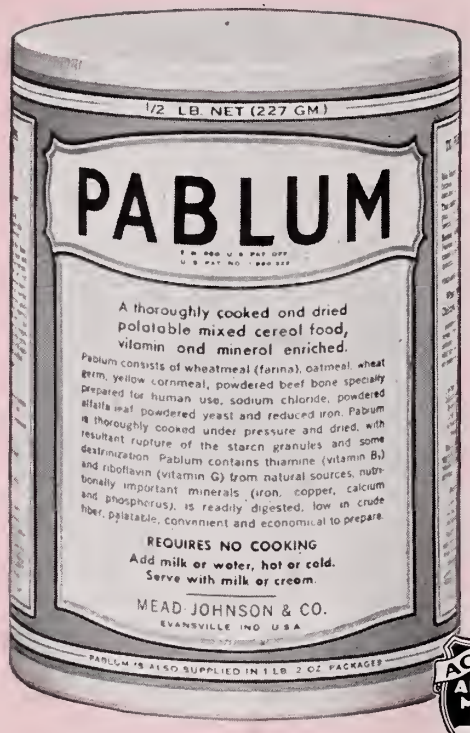
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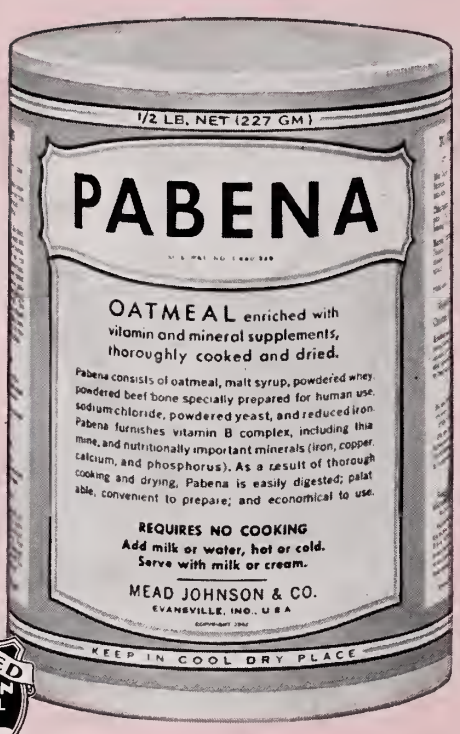
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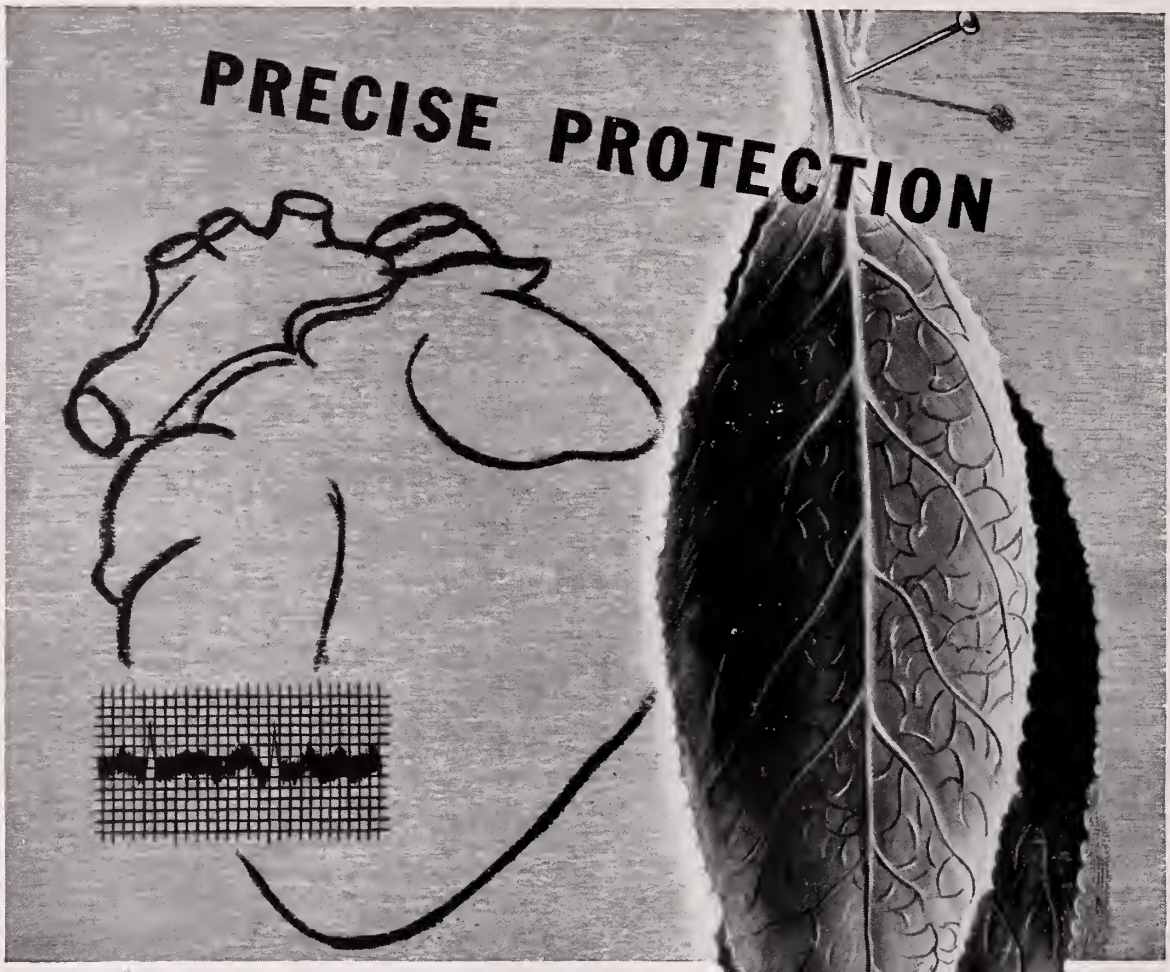
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVI AUGUST, 1943 No. 8

CHANGING VIEWS OF CONTAGIOUS DISEASES

EDWIN H. PLACE, M.D., *Boston*

The Author. *Professor of Clinical Pediatrics, Tufts College, Medical School, Boston.*

AT THIS second Charles V. Chapin Oration, I would apologize for my acceptance of the invitation to speak except for three reasons: first, no one can refuse Dr. Gormly, second, it is an honor to pay homage to the great public health worker in whose name these talks are given, and third, because of my pleasure in addressing a Medical Society which has always seemed to represent the highest qualities of professional ethics and in which I am glad to have a number of friends.

Whatever defects may dominate my remarks, you may at least be assured of the entire appropriateness of the subject. Few men in the field of contagious diseases have been more alert to the changing views, or indeed have added more changes, than Dr. Chapin.

It is inevitable in a growing science that these alterations or reversions of view should occur, and the views of yesterday change today as undoubtedly some of today's will not be held tomorrow.

The medical student, in his efforts to acquire all medical knowledge in four years, regrets the lack of static knowledge. One complained to me that he wished that the changes of opinion in regard to these diseases were less rapid so that his instructors during at least one year could agree, even if there might be considerable changes by the time he entered his hospital work.

In my student days chemists were active in food analysis in order to better adjust diet to the chemical needs. The older clinicians spoke only of liquid diet, soft solid and solid diets, or bland diets, etc. These chemical studies had shown that the views of the clinicians that cod liver oil was valuable in recovery from some disease states and for general health of children could not be true as there was no chemical superiority to sweet oil or other oils.

In the period beginning with the birth of bacteriology the demonstration of bacterial causes of disease and of sources and modes of infection led naturally to an attack on the organisms of disease in the surroundings of the sick. Every city with a progressive health department maintained crews for the purpose of rendering the premises of these cases safe after departure or recovery of the patient. This was eminently logical but Dr. Chapin quietly ignored the general view. He omitted disinfection after recovery in diphtheria and later in scarlet fever in a large series of cases and found that no more infection occurred in these families than in those in which disinfection was used. In a short time the expansive and cumbersome disinfection procedures in all our large cities was eliminated. In a series of cultures taken for a season from the home surroundings of diphtheria cases in Boston, including many of the poorest and most unsanitary, it was striking how rarely the diphtheria bacillus could be obtained from the floor, the wall and even the bed. In fact, the only places from which the organism was obtained were those usually grossly contaminated articles about the patient's head. It was evident to Dr. Chapin's clear view that the theoretical value of terminal disinfection had not been put to a practical test and with true scientific spirit he conducted the experiment that proved the lack of practical results and saved the citizens money that could be put to more useful work.

Control of Carriers

Hardly a more abrupt change of view within the period of modern scientific medicine could occur than that toward the control of carriers. At the beginning of this century carriers were just beginning to occupy a wide angle in the vision of contagious disease. Soper's "typhoid Mary" illumined the field both for layman and physicians. Millions of cultures were taken of diphtheria contacts or groups of the population and thousands and thousands of hospital days were devoted to carrier cases. Even then, however, it was evident that an attempt to ascertain and corral all the carriers was imprac-

Annual Charles V. Chapin Oration read before Rhode Island Medical Society at the Annual Meeting, on June 2, 1943.

ticable and efforts were largely devoted to those carriers discovered in relation to recognized cases.

Two years ago an alert and highly capable health officer was called on to advise a physician who had found a diphtheria carrier problem of some 15 cases in his hospital. No cases of diphtheria occurred and Schick tests showed that all patients and workers were immune as they should be. The main advice of the health officer was, "Don't take any cultures and you won't have a carrier problem". While perhaps all health officers would not have thus the courage of their convictions, or possibly might not see the soundness of this view, the refreshing and logical attitude of the health officer presents the modern view sheared of its traditions and sentiment. There are so few susceptibles now in cities with good health programs that carriers can do but little harm and to control the carriers would produce little effect and certainly an entirely inadequate return from the investment. It would be far more effective to put the money and effort into immunization. We might paraphrase Farragut's famous remark, "Damn the carriers, full speed ahead in immunization".

Meningococcus Infections

Meningococcus infections have long been a source of grave concern. The natural mortality is probably about 65%. Carriers are of significant influence. The spread of the disease is strikingly different from diseases like diphtheria or scarlet fever. Cases crop up in separated and scattered areas with no known contact. Multiple cases in a family are rare; the disease does not spread in hospitals or effect the physicians or nurses except at very rare occasions.

When it was demonstrated that this peculiar epidemiology was due to large numbers of well carriers and a widespread immunity, the responsibility of the physicians to culture all contacts and to release the patient only after being shown to be free of the organism seemed obvious. Of recent years carrier studies with typing of the organisms have shown during epidemics that the carrier rate may reach high levels—50% to 75%, or even more. When the carrier rate rises above 5% to levels around 25% to 50% an epidemic is likely to occur, but even then is not inevitable. With our present data, it is obvious that any attempt to control sources of infection would have to go beyond the patients with recognizable symptoms or even their known immediate contacts and include a large proportion of population.

It may be seen that the present tendency to ignore the carriers in this disease is not due, as in diphtheria, to the trivial danger of the carrier state nor its infrequency but simply because it is too big to tackle successfully without radically upsetting our daily life. It is not improbable with the growing knowledge of efficient means of carrier cure that the present view may again be reversed.

Epidemiology of Scarlet Fever

At the turn of the century no clinical fact was more universally accepted than that scarlet fever was markedly or even mainly spread by desquamation. Scarlet fever wards were scenes of enthusiastic scraping and sandpapering of the soles of the feet to get the patients home by the 7th or 8th week. Dr. Northrop of New York ascribed a superior success in safely releasing scarlet fever patients to his thoroughness in removing the epithelial scales, even those in the auricular canals. There was no pediatric textbook but emphasized the importance of desquamation. The first clinical study which fell to me under McCollom was the investigation of a considerable number of scarlet fever cases found to be infectious after supposed recovery. The evidence was entirely clear that contagion was in no way related to desquamation but to residual infections in the throat, ears, nose or lesions of the skin. The subsequent release of patient without regard to desquamation encountered much skepticism and until the demonstration by the Dicks of the streptococcal etiology and pathogenesis of scarlet fever it was not entirely approved. I hazard the opinion that the present view of the lack of contagion in desquamation per se is not likely to be revised in the future.

Regarding the epidemiology of scarlet fever a significant change has been wrought during the past twenty years which has unsettled isolation theories in an almost revolutionary manner. Previously, although a few workers had glimpsed the truth and many had had suspicions, there was essential unanimity of opinion that scarlet fever was a specific form of disease like diphtheria, breeding true in the main. The practically universal appreciation that the streptococcus was closely and almost always associated with the clinical manifestations did not strongly negative this view. Similar streptococci were frequently found in other clinical conditions as small pox and sepsis in general. Following the proof of its streptococcal etiology, agglutination studies at first indicated that a peculiar strain, streptococcus scarlatinae, was the cause. This was due to the natural selection for bacteriologic study of

localized outbreaks. However, it was soon shown by Griffiths, Smith, Parish, Okell and many others that the streptococci from scarlet fever might belong to any of the 27 immunologic strains. Even the toxin, unlike the diphtheria toxin, was of varied constitution antigenically and that although some strains were eminently toxin producers, this did not constitute a fixed characteristic. Many studies showed that one strain might produce scarlet fever or other of the clinical manifestations—as erysipelas, tonsillitis or septicemia. On the other hand, some epidemics like one in Greater Boston due to a common source spread through milk, produced a widespread epidemic of practically pure scarlet fever, and epidemics of septic throat occurred, such as the Lee epidemic, in which scarlet fever forms are practically absent. And in spite of the varied character of the toxin most antitoxins or convalescent serums are effective against the great majority of cases.

These upsetting additions to our knowledge of scarlet fever have now left us in some turmoil as to the procedures. Of course, there is abundant evidence that scarlet fever is contagious and that the admission of a case into a susceptible group is followed usually by outbreaks of varying extent and severity. The vast majority of cases follow a fairly typical clinical pattern. Isolation, quarantine and other preventive measures have been very extensively practiced, although so far as evidence can be secured without any effect on prevalence.

Approaches to Streptococcal Infections

But now we are confronted by the fact bacteriologically and epidemically that any B-hemolytic streptococcus may produce a variety of clinical forms—as scarlet fever, erysipelas, septic sore throat, tonsillitis, pharyngitis, rhinitis, otitis media, impetigo, wound infection, septicemia, etc. Moreover, the strept. pyog. is a frequent parasite of normal throats and the carrier rate may rise to high levels as 50%, sometimes without any scarlet fever outbreak. While we are accustomed to attempted isolation of all scarlet fever cases we do not approach all the streptococcal infections in the same spirit. While we might isolate even a high percentage of clinical scarlet fever it is not practicable to isolate all the cases and carriers of streptococcal disease. Without present facts, the logical procedure would be either to give up all our efforts of isolation of scarlet fever or else to isolate all forms of streptococcal infections including the carriers. I do not know as yet of much voluntary selection of either horn of this dilemma. Personally, I do not advocate *invariably* carrying reasoning to a logical conclusion. There are too many chances that there may be some defect in our premises or our logic. In the early part of the century a German investigator found that B. Diphtheriae was so widespread in nature as to make the isolation of its few diphtheria victims entirley illogical and useless. Subsequent investigations, of course, showed that the Cornebacterium family consists of a large variety of species most of which have no significance in human disease.

The difficulty of the practitioner either in medical practice or public health is that he cannot postpone his opinion until all possible data has been worked out. He cannot say as may the abstract scientist, "At present we cannot say, much more evidence will have to be secured and sifted before I can give an opinion." The practitioner must make a working plan out of the present data. The garment is necessary now and will have to be cut from the cloth even if there are many gaps in the pattern.

Immunization Must Continue Unabated

In diphtheria the great change in the past 20 years has not been so much in point of view as in undisputed fact. Diphtheria has become rare. It must be difficult for the young physicians of today, many of whom have not even seen a diphtheria case in the medical course, to comprehend the situation of 30 years ago. The facts of the past recorded by history do not seem to have the reality of those of present experience. I do not believe that we comprehended the significance of McCollom's frequent reference to diphtheria before antitoxin when 45% of the hospital cases and practically 90% of the cases with laryngeal obstruction died. The drop in the morbidity and mortality of diphtheria is one of the bright spots of modern preventive medicine. Possibly many factors have been responsible for the long continued drop in diphtheria mortality; some of these factors are unknown. There was a well marked fall of mortality before antitoxin and the drop since has continued at much the same rate if mathematically corrected. But there is no doubt that the present freedom from danger is due to immunization. The present cases occur in non-immunized persons or those in whom the method used was inadequate, except with rare exceptions. The disease still occurs in about its previous forms and severity. The mortality at the South Department for the past 10 years was 7.7. The cardiac complications occur in about 5% and paralysis oc-

curs in about 16%. There is no basis as yet for the belief that the disease has "lost its punch" or is on the way to extermination. We must continue unabated our immunization efforts.

Since 1931 the studies of McLeod and his colleagues and others have brought new data regarding the diphtheria bacillus. They showed that diphtheria strains varied in colonial characters on media containing potassium tellurite and that strains so classified differed in their chemical behavior. The gravis strains fermented starch and glycogen and were usually non-hemolytic, while mitis strains did not ferment these carbohydrates and were hemolytic. The intermediate strains simulated the gravis culturally except they did not ferment starch and glycogen. In Leeds' the gravis strains were associated with more severe and fatal cases than the mitis or intermediate. Other workers have confirmed these facts in the main. Some reports have been made indicating that gravis cases do not respond to antitoxin and that active immunization does not protect.

The toxin of the gravis type does not differ from the other types antigenically and therapeutic effects should be the same. In the Halifax cases the death rate was under 5% which is a little better than our usual mortality. It is probable that some lack of experience with severe diphtheria has failed to acquaint them with the fact that after a diphtheria patient has been given adequate antitoxin the inflammation may spread for 24-36 hours. This, of course, is not a peculiarity of the strain but is due to the impossibility of neutralizing toxic damage rather than toxin. Tissue-combined toxin, if in large amount, will continue the inflammatory process for 24-48 hours and is not influenced by antitoxin. Death may readily occur from poison acting within the first 48 hours and no dose of antitoxin will save the patient.

It is not yet certain whether the behavior of strains of Cornebacterium diphtheria on tellurite media is a fixed characteristic nor that the preventive or therapeutic principles are necessarily modified.

Importance of Public Relations

The history of epidemics is often high lighted by fear and dread. Escape by fleeing seemed the only course, the dangers of the unknown seeming less than the dangers around them. With modern transportation it is fortunate that this view has changed or extraordinary surges of humanity would be seen. The change is not entirely due to the marked decrease in danger today and to efficient means of controlling some epidemics; it is to no small extent due to public education, the great banisher of fears. Will Rogers used to say "All I know I read in the papers". And, in fact, a person may obtain an enormous amount of medical information from news and magazines. It is not a rare embarrassing moment to have some layman who has just read a complete and accurate account in one of the popular magazines, perhaps in a field a little beyond your busy tilling, discuss a medical question with more knowledge than his physician.

In addition, the mortality of these diseases has shown an enormous drop. In Boston the diphtheria death rate has fallen from a peak of 217.4 per 100,000 in 1881 to 0.2 in 1940, a decrease of 99.9%, and scarlet fever has dropped from a peak of 156.2 per 100,000 in 1875 to 0.2% in 1941, a decrease of 99.8%. Small pox and typhoid have similarly been reduced and measles, pertussis and tuberculosis have shown nearly as marked a reduction in death rate.

These facts have induced in the layman a natural sense of security, so that the avoiding of localities or sides of the street of contagious cases is not so prominent a feature of neighborly behavior as a generation ago. One can look with gratification at this change of attitude except for one feature. When persons erroneously conclude because these dangers have been so enormously reduced, that no danger remains in any case, then grievous harm may result which could be easily avoided.

Results of Hospital Isolation

One facet of the contagious disease problem has turned through a complete revolution during this century. The fond belief that the contributions of the isolation hospital to adequate control of contagious disease prevailed to a considerable extent at the outset of the period. It seemed obvious that the substitution of good isolation for the very inadequate conditions prevailing in many homes, especially of the less wealthy, would have a marked influence in the prevalence of disease.

In England, particularly, the effort to hospitalize all cases of contagious disease was made. That hopes of control by such means have not been fulfilled is well known. Even granting that hospital isolation will be completely carried out, and invariably for an adequate time, it takes but a slight familiarity with the extreme variation in severity and form of these diseases to know that all cases will not be recognized. With the average of human carelessness it is equally clear that isolation will not be invariably practiced at the outset of infectivity.

And, in fact, in many—as pertussis and measles, it is entirely clear that even under the best of conditions this is impossible. I am sure that the contribution of good hospital isolation is not without effect on the prevalence but it cannot in itself reduce the number of these diseases in the community to a degree to be considered control.

The present trend of hospitalization is, therefore, as in other diseases, to care for those cases whose medical or social home conditions are inferior.

That improving isolation may be a benefit can be maintained by some evidence. It has been proved that rapid passage of a pathogen through a series of susceptible hosts may increase its virulence and invasiveness. Organisms obtained in diphtheria cultures after the patient has developed immunity have been shown by Shibley and Rogers and others to have a lower virulence. Good isolation, therefore, may tend to reduce the virulence of infection although all cases of the disease are not isolated. The most serious cases as a rule are isolated leaving the milder forms to serve as sources so that as virulence falls, immunity rises.

Relation of Air to Infection

There remains of several examples of the rotation of medical views one of great interest and considerable practical importance, that of the relation of air to infection. While the conception of air-borne diseases is as ancient as Hippocrates it received a basis of scientific evidence in the proof by Pasteur by simple but ingenious tests that fermentative bacteria were present in the air. Lister made application of the idea to wound infection and secured freedom from infection in operative wounds by phenol air sprays, but soon became convinced that contact with the wound was the chief factor, at least, and inaugurated an aseptic technique which demonstrated primary healing of wounds without pus, either laudable or otherwise; Flugge and Leschtschenko showed by experiments that the range of infection by coughing was limited to a zone of 2 meters. This was corroborated by Winslow at the Mass. Institute of Technology and others and became the basic principle in handling infections. Grancher published a monograph showing the adequacy of barrier isolation even with a simple screen about the bed in the isolation of contagious diseases and this was practiced with eminent success by him on the Höpital des Malâdes. Buildings constructed in the latter part of the last century at the Boston City Hospital of cheap and simple construction with the idea that they would soon have to be torn down and replaced because of becoming saturated with bacteria remained in active service for 3 times their planned existence and were only replaced by the Burnham Memorial Building and the Thorndike Memorial Building in the natural growth of the hospital. Contagious hospital technique was soon based on these ideas of contact infection and in this work Dr. Chapin contributed extensively. The importance of air infection was generally accepted as of no practical significance. It is true that here and there evidence was seen which threw some doubt on the limits established by Flügge and his followers. The English physicians insisted that small pox appeared about small pox hospitals to a definitely higher degree to the leeward from prevailing winds than to the windward. A considerable number of clinicians continued to have difficulties in the isolation of measles which were not thought to be entirely due to faults in contact preventive technique.

In an extended experiment it was found by Karaxony working under my direction that with the most complete separation of contact possible in measles cases, the disease was contracted by susceptibles as far away as thirty feet.

It was not forgotten that British clinicians had insisted that typhus, then a scourge of hospitals, could be much more safely isolated in the wards if kept to the end of the ward at the large fireplace which supplied the heat. This location prevented the air from the typhus cases being carried to other patients. Such fallacious evidence tended to discredit all air borne infection when the louse vector was discovered. The view of the unimportance of air in both surgical and medical asepsis became about as firmly fixed as most our conceptions.

In 1926, Dunkin and Laidlow in reporting their epochal researches on dog distemper in dogs and ferrets gave the elaborate precautions necessary to prevent the spread of disease accidentally in their experimental studies and affirmed their belief that air borne infection occurs both indoors and outdoors, at least for short distances.

In 1934, McCoy while his laboratory was working on psitticosis, observed an epidemic in workers in his laboratory which could not be reasonably explained except by air convection.

Recent Striking Experimental Evidences

The most striking experimental evidences on this subject have appeared during the past 10 years inaugurated by the studies of wound infection by Hart and the epochal experiments of Wells. Wells

showed that while larger droplets fell to the ground as demonstrated by Flügge and others within a radius of 3 feet, the smallest droplets (of less than 0.1 mm. diameter) lost their water within a third of the time necessary to reach the ground from the height of a man. These evaporated droplets, which he called droplet nuclei, failed to follow the law of falling bodies but remained suspended in air for hours or days. By means of a strong light beam through an experimental chamber he showed by the Tyndall effect that salt solution or suspensions of bacteria when sprayed into the chamber in very fine mist produced a haze lasting for hours or days. The persistence of the chemical or the bacteria in this haze was shown by appropriate means. He devised a method of bacterial testing of air which allowed of securing much larger samples than had ever been studied before and of securing a more reliable bacteria count by means of centrifugal force.

Extensive applications of this technique showed that even in still air, and especially in air agitated by the movements of people, large numbers of bacteria may remain suspended for as long as two days.

Brown and Allison showed, in 1937, the presence of streptococci in considerable number in the air of scarlet fever wards. During the height of morning activity counts as high as 334 colonies in 3 hours were found in Petri dishes by the sedimentation technique which gives much lower counts than the Wells centrifuge.

Hart, by persistent and careful studies, has shown the influence in operating rooms of air infection in large wounds exposed by long operations.

Buchbinder, Solowny and Salatorovsky in extensive studies of bacteria in air in New York City, using the Wells technique, have found streptococci, group A, in schools, streets, air-conditioned and non-air-conditioned theatres, subways and even in Central Park. Little data is available to determine the bacterial concentration in air that would determine clinical danger but studies with ultraviolet light air sterilization have not only shown the possibility of rendering the air free from organisms but have shown increased safety from infection.

Del Monte and McKhann have shown that freedom of infection may be thus secured.

Greene, Barenberg and Greenberg showed a marked reduction in the spread of chicken pox in wards with ultraviolet irradiation and Wells and Brown demonstrated that air sprayed with influenza virus A from ferrets' lungs remained infectious for ferrets for 30 minutes but was entirely sterilized at once if the air was passed through an ultraviolet field.

English workers have approached the subject largely through air sterilization with finely atomized mists, the so-called aersols. Proprolene glycol has been shown to be highly effective as well as harmless to humans and their surroundings. Ethylene glycol is even more effective bacteriologically but its harmlessness to humans has not been well established. Enough work has been done to prove the importance of infection at least under crowded conditions and for short distances but much beyond that of the limits of the classic droplet infection.

While this brings important data to the problems of preventive medicine, there is no reason to allow the swing of opinion back to the period of Pasteur. Dilution by ventilation, solar disinfection and other factors clearly indicate the lack of bacterial air danger in general. Only under limited conditions in the actual vicinity of man and particularly indoors is there danger of infection through air. Even then we have no definite figures as yet which measure the dangerous degree of air contamination.

Chapin's conclusions in 1910 that "It may be fairly affirmed that there is no evidence that air infection is an appreciable factor in the maintenance of most of our common contagious diseases". are not seriously contrary to present evidence. The emphasis has changed, but if we added "To some degree air borne bacterial disease has been demonstrated possible, and in some of the virus diseases, —as measles, psitticosis, etc., air borne infection must be reckoned with", it would be more accurate.

This may well close the consideration of these examples of the shifting views of contagious disease problems. One should not conclude that medical opinions are generally unstable and show kaliedoscopic changes. Dr. Chapin once said, "Science—is like a tree, ever growing, ever reaching new heights. Occasionally the lower branches, no longer giving nourishment to the tree, slough off. We should not be ashamed to change our methods; rather we should be ashamed never to do so." With the still incompleteness of our knowledge, pendulum swings may be expected but the range of the swings is narrowing and the pendulum will point more and more constantly at the truth. Until then it behooves us to keep as free as possible from bias and to keep an open but not an empty mind.

The RHODE ISLAND MEDICAL JOURNAL

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106 Francis Street, Providence, Rhode Island

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PRE-ELECTION PLEDGES

A YEAR AGO the medical profession was aroused by the National Physicians Committee for the Extension of Medical Services to carry on a program which called for the securing of pre-election pledges from candidates for Congress. In substance the program sought support of medicine as presently organized, and it included a pledge from congressional aspirants to vote against (or for) "legislation the effect of which would be authorization for providing medical care by laymen or by others than duly qualified Doctors of Medicine." The NPC post-election report claimed overwhelming support of organized medicine by legislators.

The first real test of these pledges came during the past month. The appropriations bill for the obstetric programs of the Children's Bureau was passed by the House containing a proviso that no part of the funds could be used to carry out any instruction, order, or regulation relating to the care of obstetrical cases which discriminates between persons licensed under State law to practice obstetrics. The Senate Committee on Appropriations, of which our Senator Green is a member, reported the act to the Senate with the recommendation that this proviso be stricken from the bill. The Senate acquiesced and passed the act June 29.

Then followed a conference committee study which resulted in the restoration of the proviso with the additional clause that "the proviso shall not be construed as to prevent any patient from having the services of any practitioner of her own choice, paid for out of this fund, so long as state laws are complied with." The doctors in Congress opposed the proviso in toto and they received some support from those who recognized in the clauses an intrusion of the right of the separate state health departments to regulate their health programs so as to administer the best possible obstetrical care. In spite of the objections, the act, with the proviso included, was adopted by both the House and the Senate.

This action is significant for several reasons. It indicates a new approach by cultists to make inroads on public health programs through riders on appropriation acts on which both political groups are always anxious to avoid controversy. The same procedure was adopted to gain for osteopaths the status of potential candidates for commissions as medical officers in the Navy. It also indicates a disregard for the importance of assuring the best possible obstetrical care for the wives of the men serving with the armed groups by forcing the individual states to alter their regulations to admit every person licensed in obstetrics into the program

equally—thus the doctor of medicine and the midwife are given the same status in a program that aims at the best possible health care under federal-state administration.

But the situation is far more tragic when one realizes that this action marks the first significant nationwide invasion of public health administration by sectarian healers and laity, for in no other health program, to our knowledge, is equal status given to such branches of the healing art in the medical care of the people. That Congress should force the States to alter their individual regulations to meet the terms of the new act, under the possible threat of loss of funds to carry forward the obstetrical program, shows utter disregard for local conditions in the States. Here in Rhode Island, for example, we have some persons licensed to perform obstetrics who are in practice pending appeals to the higher courts on the revocation of their licenses, and the memory of the licensure frauds so ably exposed by the *Providence Journal* two years ago is still fresh in our mind.

The Rhode Island Medical Society did not participate in the pre-election pledge campaign instituted by the NPC. We were of the opinion that our Congressional delegation was fully cognizant of Rhode Island problems, and entirely competent to determine what is best for our people. That faith has been justified in their treatment of the controversy on the obstetrical program. Senator Green was a member of the Senate appropriation committee which struck out the proviso. Senator Gerry voted against a motion that the Senate agree to the conference report which advocated retention of the proviso in the bill. Representatives Fogarty and Forand voted to support Representative Judd's motion in the House to return the bill to conference with instructions to the House conferees to concur in the action taken by the Senate in eliminating the proviso in its entirety.

By their action our delegation endorsed the principle of the medical profession that all federal and state programs should seek to provide the highest standard of medical care for our citizens. We wonder how many of the Congressional candidates of other states who so freely gave pre-election support of organized medicine can equal the action of our representation?

BURNS

The June issue of the Annals of Surgery is devoted nearly entirely to a discussion of the various medical aspects of the Boston Cocoanut Grove Disaster. This disaster provided a laboratory experiment on a scale large enough to be of value. That Burns and their Treatment are very much in the medical consciousness at present, such a series of articles well illustrates as do also the numerous papers throughout current medical literature, the article on burns in the Official War Manual and circulars of the Office of Civilian Defense. The average medical man's business is the application of therapeutic measures. So it is the usual pattern for an increase in interest in a medical subject to occur when advancement of knowledge has led the way for an advancement in treatment. In this instance it is the increase in knowledge of the pathology and physiology of burns which has made possible, when joined to the development of the sulfonamides, the more rational and, in general, easily applied modes of treatment.

Tannic acid and other eschar producing agents gave results which were a long step in advance. The improvement probably was due to control of fluid loss with some control of infection rather than lessened toxic absorption. The disadvantages of destruction of residual epithelium, the damming up of infection and occasional toxic by-effects have led, in light of increased knowledge, to the abandonment of this method in favor of non-adhesive dressings, pressure control of serum loss—Shades of Gamgee—, infection control by technic and sulfonamides, shock control by plasm transfusion, deformity control by early flaps and grafts. While these methods are not all applicable in the field under war conditions, modern transportation is bringing most casualties to definitive treatment rapidly. These lessons from war and disaster must be learned and applied by our civil hospitals. Perhaps the most valuable contribution to come from the Cocoanut Grove disaster has been the demonstration of the necessity for an intelligently planned, pre-determined course to be followed in handling a disaster.

VICE-PRESIDENT WHEATON

The Council of the Rhode Island Medical Society have elected Dr. James L. Wheaton, of Pawtucket, Vice-President, this office having become vacant by the accession of Dr. Sullivan to the Presidency.

We congratulate another of our neighboring cities for a fine contribution to our list of officers.

Dr. Wheaton is exceedingly well known to our members as he has been prominent not only in the medical life of the community but has taken a dis-

tinguished part in military and civic activities. A graduate of Brown and the Harvard Medical School and with a European training he has been an outstanding member of the staff of the Memorial Hospital in numerous capacities.

Like our last Vice-President from Pawtucket, Dr. Holt, afterwards President, he has had an extensive military service, rising to the rank of major. And besides serving as President of the Association in his own city he has held important posts in Health work, Red Cross, Y. M. C. A. and other public spirited organizations.

We are pleased that he has become a member of our governing board.

With the election of the new vice president the Council of the R. I. Medical Society is complete for the year, as follows: Dr. Michael H. Sullivan of Newport, chairman; Dr. J. L. Wheaton of Pawtucket, Dr. Elihu S. Wing, Dr. William P. Buffum, secretary, Dr. Alfred L. Potter, Dr. Jesse E. Mowry, Dr. Charles J. Ashworth, Dr. Roland Hammond, Dr. John E. Donley, Dr. Edward S. Brackett, Dr. Lucius C. Kingman, and Dr. John G. Walsh, all of Providence; Dr. W. C. Rochleau and Dr. Leo V. Conlon, both of Woonsocket; Dr. Rocco Abbate of Lakewood; Dr. Norman M. MacLeod of Newport; and Dr. John P. Jones of Wakefield.

NEW FORMAT

In keeping with the trend of the day the JOURNAL dons a new uniform with this issue. Other changes aimed towards making our publication of greater service to the members include new style headings, extension of the reading page, introduction of new departmental sections, and reassignment of advertising space. We hope you like the new JOURNAL.

AFFILIATED HOSPITAL UNITS

Many words have been written, and probably twice as many spoken of the contributions of citizens to the protection of the civilian population during the war period, but it is to be doubted that a more responsive group is to be found than the medical profession. Long before Pearl Harbor the doctors of the country started marshaling their forces for any emergency, and that preparation resulted in the outstanding medical care since given our armed forces in every theater of combat.

On the home front the medical forces, depleted by losses to the Services, have done an equally remarkable job in safeguarding civilian health and safety. All this work has been accomplished at a time when every doctor finds himself overburdened with the task of meeting the demands for his time and services.

The latest example of immediate response to civilian defense as well as cooperation with the military forces is the organization of affiliated hospital units at two of our local hospitals. In April 191 hospitals and medical schools in coastal areas were invited to provide balanced medical staffs for emergency base hospitals which would operate in the event of an extraordinary military emergency. Both the local hospitals selected have already organized their units to provide temporary medical care in extreme emergencies for military personnel in extemporized hospitals in the area, and to provide care for civilian casualties and other hospital patients who must be moved out of their communities because of enemy action. The personnel of these units as presently organized is as follows:

RHODE ISLAND UNIT

GEORGE W. WATERMAN, Sr. Surgeon (R) Unit Director, Chief of Surgical Services, Lieut. Colonel
EMERY M. PORTER, Surgeon (R) Asst. Chief of Surgical Services, Major
EDWARD S. CAMERON, Surgeon (R) General Surgeon, Major
ALEX M. BURGESS, Sr. Surgeon (R) Chief of Medical Services, Lieut. Colonel
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PHILIP BATCHELDER, Surgeon (R) Radiologist, Major
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WALTER H. POTTER — Orthopedic Surgeon, — Surgeon
RUSSELL R. HUNT — Surgeon — Radiologist
FRANK C. MACCARDELL—Surgeon—Nose and Throat
GEORGE R. MANKIS — Assistant Surgeon
FRANCIS H. MCCAFFREY — Assistant Surgeon
GUSTAVO A. MOTTA — Assistant Surgeon
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A.M.A. HOUSE OF DELEGATES MEETING

June 7-9, 1943 at Chicago

WILLIAM P. BUFFUM, M.D., *Alternate Delegate*

The 1943 Session of the House of Delegates of the American Medical Association was outstanding in accomplishment. The most important step was the establishment of the Council on Medical Service and Public Relations which promises to give us the intelligent leadership which is obviously necessary in fields of government—subsidized medicine and prepaid medical care. Many other important matters were dealt with and wise reports adopted.

The Scientific Session of the A. M. A. was omitted this year. The House of Delegates held its annual meeting in Chicago on June 7, 8, and 9. There was present a full delegation from each state and the only absences were among the delegates from the distant territories.

Dr. James E. Paullin, of Atlanta, Georgia, was inducted as President, and Dr. Herman L. Kretschmer, a distinguished urologist of Chicago, was chosen President-elect.

The Distinguished Service Medal was awarded to Dr. Elliot P. Joslin of Boston.

The House of Delegates recommended to the Federal Government that in planning for obstetric and pediatric care for the wives and children of enlisted men in the Armed Forces that arrangements be made to make the payments in cash to the patient. The patient can then make her own arrangement with her physician. This procedure will avoid certain troubles arising from differences in fee schedules which are customary in rural as opposed to urban districts, with general practitioners as opposed to specialists, and in low income areas as opposed to communities which are prosperous from war industries. The general opinion was that such a procedure will, if adopted, set a good example for other projects in the field of subsidized medical care.

In a voluminous supplemental report the Board of Trustees reviewed the entire problem of medical services rendered by hospitals, particularly since the advent of the group hospitalization plans. The report in its entirety is to be found in the *Journal* of the A. M. A. of June 19th, and the *Journal* of June 26th is printed the report of the Reference Committee of the House of Delegates on the same topic. Every doctor will find these reports worthwhile reading.

In these reports it is strongly emphasized that medical services including radiology, pathology, and anesthesiology should not be sold by the Blue Cross plans, and a constant guard against the invasion of medical practice by a third party must be continued. In view of the variance of conditions in different sections of the country, the House included in its recommendations the request that the American Hospital Association withhold approval of any uniform comprehensive Blue Cross contract such as has been proposed by the Hospital Service Plan Commission and which includes certain medical services as part of hospital care.

There was a strong move to establish an active office of the American Medical Association in Washington. A motion was also introduced to create a council on Medical Economics. The final result was the establishment of a new Council on Medical Service and Public Relations of six elected members, two to be elected each year except that the first year the Board of Trustees appoints the members. Also on the new council are the President, the immediate past President, and a member of the Board of Trustees. The Council will study medical plans of all types and will suggest policies and report them to the State and County Medical Societies for their consideration and action. The facilities of the Legislation Bureau and of the Bureau of Medical Economics are made available for the Council. This Council can be confidently expected to furnish a high grade of leadership in working out the problems in prepaid medical care and government subsidized medicine.

In closing I should like to pay tribute to the Members of the House of Delegates. In general the State Societies are sending their best men and these men are working hard to do a good job. It has been an honor to be associated with them.

MEDICAL LIBRARY NOTES

COMMITTEE ON THE LIBRARY:
Herbert G. Partridge, M.D.; Samuel Adelson, M.D.; Adolph W. Eckstein, M.D.

THE Librarian of the Rhode Island Medical Society Library announces the recent addition of the following books:

GYNECOLOGY

Lawrence R. Wharton—Gynecology, with a Section on Female Urology. Phil., 1943.

HEART

Fredrick A. Willius—Cardiac Clinics. A Mayo Clinic Monograph. St. L., 1941.

INDUSTRY

William M. Gafafer, editor—Manual of Industrial Hygiene and Medical Service in War Industries. Phil., 1943.

Willis M. Lasher—Industrial Surgery. Principles, Problems and Practice. N. Y., 1942.

OBSTETRICS

Joseph B. DeLee & J. P Greenhill—The Principles and Practice of Obstetrics. 8th ed. Phil., 1943.

PROCTOLOGY

Transactions of the American Proctologic Society, 43rd ser., 1942.

PSYCHOLOGY

Edward Weiss & O. Spurgeon English—Psychosomatic Medicine. The Clinical Application of Psychopathology to General Medical Problems. Phil., 1943.

SURGERY, military

Military Surgical Manuals, National Research Council—Vol. V—Burns, Shock, Wound Healing and Vascular Injuries. Vol. VI—Neurosurgery and Thoracic Surgery. Phil., 1943.

J. Trueta—The Principles and Practice of War Surgery with Reference to the Biological Method of the Treatment of War Wounds and Fractures. St. L., 1943.

THERAPEUTICS

Windsor C. Cutting—A Manual of Clinical Therapeutics. Phil., 1943.

VENEREAL DISEASES

Russell D. Herrold — Chemotherapy of Gonococcic Infections. St. L., 1943.

Special Gifts

A valuable gift to the library collection this month has been the acquisition of 91 volumes of the DENTAL COSMOS. This very complete history of dentistry is the gift of Charles J. Smith, D.M.D., of Providence.

The Committee on the Library also acknowledges the gift of A MANUAL OF ETHERIZATION, by Charles T. Jackson: containing Directions for the employment of ether, chloroform and other anaesthetic agents, Bost., 1861, from Dr. Peter Pineo Chase.

An unusual and valuable gift made recently to the Library is a mahogany case containing a complete set of surgical instruments used by military surgeons in the time of the Civil War. The gift was made in memory of the late Dr. Leonard E. Norris by his father, and it is now on display in the library reading room.

Library Hours for August

During the month of August the Library will open daily at 9 a. m. and will close at 1 p. m., except on Saturdays when the closing hour will be 12 noon.

Book Review

"MEDICAL MALPRACTICE". By LOUIS J. REGAN, M.D., LL.B. The C. V. Mosby Company.

Dr. Regan's recent book, "Medical Malpractice", seems to be a valuable addition to the working library of the doctor and the lawyer alike, not to mention the dentist and the nurse. The author has had the unusual advantages of degrees both in medicine and law. This may account for production of a readable, condensed, but comprehensive summary of court decisions in this field. The book is well arranged and adequately indexed by subjects and States. Not all the Rhode Island decisions appear, but a case as late as 1933 is cited.

The volume contains some helpful suggestions (somewhat reiterated) on what is termed "Malpractice Prophylaxis", i. e., ways to prevent malpractice suits.

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** Proc. Soc. Exp. Bio. and Med., 1934, 32, 241-245 ** Laryngoscope, 1935, XLV, No. 2, 149-154*



NEWS FROM THE WAR FRONT

MESSAGE FROM THE HOME 'FRONT'

Medical Library,
106 Francis Street,
Providence, R. I.

To the Doctors on the Fighting Fronts:

Having written of your activities for more than a year in the NEWS I figured that it might not be amiss for a message from the home front to be addressed to you who are scattered all over this world in the battle for the freedom so necessary for peaceful ways of living.

Life in these Plantations is hardly more exciting because of the war, and for the most part it appears to be as it was when you were last here—except that the people in general have rediscovered the full happiness of home life as the result of gasoline rationing. We all grumble a bit about the scarcity of some foods and of the problems of rationing, but beneath it all I think we are for the most part very much in the war and in our humble way trying very hard to back you up in your front line attack.

We don't have as many doctor-visitors at the Library as we did a year or so ago, for the time of the men here now makes little allowance for either research or "escape" reading. Each day, however, brings along its varied problems on medical care and medical services for the various committees to consider, that the future pattern of American medicine may not be distorted. Be assured that your colleagues on the home front are alert to the threats to private medicine which are arising under the guise of war or defense needs, and your executive secretary sincerely hopes that while you are away he may continue to be of material assistance in the task of protecting your stake in the future medical practice in Rhode Island.

The summer has seen little letup in our activities. Yesterday, a typical day in many ways, saw us reviewing the entire program of obstetrical care for the wives of men in service as proposed under the Children's Bureau of the federal Labor Department.—Conferring with the state health authorities.—Making a hurried visit to the State OPA headquarters to discuss the gasoline rationing as it affects doctors and also to urge the adoption of a standard form for supplemental food rations to be filled out by the doctor for sick patients.—Off to the state defense office for a conference on a statewide recruitment program for nurses for the armed forces and for civilian needs—and also to confer with the Civilian War Services division relative to an immunization program to be publicized through the block plan.—Back to the office to advise a prospective student on his plans for a medical career before he joins the Army.—Then to hear the complaint of an industrial authority relative to workers shifting from one defense job to another via a doctor's certificate given in good faith.—A doctor's wife visits us to ask our aid in collecting accounts long due her doctor-husband now with the armed forces and we solve the problem to her satisfaction. —A brief spell of typing for the new *Journal* . . . and then it is six o'clock and time to head home.

Waterman street is different to me, somehow. Marching students swing along Brown street reminiscent of the ROTC of War I, but quite different in their quarter-sleeve shirts, their GI fatigue hats, and their navy blue shorts. Singing en route they disappear into the main campus. Autos at the curbs indicate that many doctors are still in their offices. Here a nameplate of a doctor in the Services is missing; there one swings on a sign and I wonder if there is a breeze as cool in far-away India where the doctor is now stationed. Passing Thayer street thoughts of Dr. Gormly return, and I think how fine it will be for you men who knew him so well to come back and see his portrait in the Library and to recall how devoted he was to the profession. Hope street now and I am halted as more marching students return from physical drills at Aldrich Field, and I think of yesteryears when I took Providence College ball clubs over there to battle Dave Freedman's Brown nines.

Governor street and I toot my auto horn and wave to Dr. Jones' children (though they do not know

(Con'd on Page 131)

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me) and I think of him and the many other doctors —Wells, Murphy, Lawson, Cutts, to name a few— in far-away places who left their homes and families to help make this world a peaceful one forever for all our children, and I think of the great sacrifice made. Ives street and I recall visits to Dr. Dziob to discuss credit and collection problems for the committee of the Association which he headed, and I wonder how he is faring now with the problem of mastering the Chinese language. Gano street and a patient on crutches to ease a leg in a cast comes along from Drs. Hammond and Harris' office and thoughts of war casualties leap to view. Red Bridge brings to view war workers (mostly women in slacks that are probably far more comfortable than they are attractive) heading for buses. Through East Providence, along the Agawam Hunt club whose fairways are deserted, then past Drowne Parkway where Dr. Sanborn waits word of a son missing in the Pacific area and I remember again that doctors often give far more than professional services in a war.

Home at last with my family. Headlines of bombings of Rome, success in Sicily, attacks in the Pacific, and devastation in the Ruhr valley. Perhaps the end is in sight; may the final march be swift and with little loss of life. And so, with a prayer for the safety of our fighters everywhere, our day is ended.

Till you return to little Rhody then, the best of luck to all of you.

JOHN E.

With the Rhode Island Unit concentrating on hospital work near a major Indian city until the monsoons cease, and with the Army and Navy on the march in the Mediterranean and Pacific areas we must await a future date for definite news of the whereabouts of many of our doctors who are in the combat zones.... Meanwhile we note with interest this month of the promotions of five Rhode Island doctors.... Upped to the rank of lieutenant commanders are Drs. Herman Marks, William J. Schwab, and H. Frederick Stephens, while Major James P. Healey of Central Falls has been made a lieutenant-colonel, and Lieutenant Louis D. Lippitt of Providence, a captain.

We thought that Dr. Stanley Freedman was on foreign soil when we first read his new address as it is Don-Ce-Sar Hospital, Pass-A-Grille, FLORIDA.... New APO addresses have been received from Lieut. Stanley Grzebien, of Providence, who has seen much active duty in the Pacific area, and from Major John A. Mellone who is also in a combat zone.... From Captain Alfred L. Melucci of Pawtucket comes a greeting from San Diego, where he is stationed with the Aviation Cadet Examining Board, to inform us that the arrival of the State MEDICAL JOURNAL is most welcome news from home.

Lieut. Edward Lincoln Smith, whose brilliant story of Guadalcanal from a doctor's viewpoint won national recognition following its publication in the *Providence Medical News,* is scheduled to break into print again soon with an article in *Harper's*.... Dr. Smith is now stationed at Arizona State Teachers College in Flagstaff.

ASSIGNMENTS

LIEUT. JAMES WEBBER LENT, MC, V(S), USNR, Massachusetts Maritime Academy, Hyannis, Massachusetts

LIEUT. WILLIAM H. TULLY, MC, USNR, Portsmouth New Hampshire

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CAPT. STANLEY S. FREEDMAN, MC, to 3rd Air Force, Don-Ce-Sar Hospital, Pass-A-Grille, Florida

LIEUT. SEEBERT J. GOLDOWSKY, to 30th Evacuation Hospital, Camp Barkley, Texas

LIEUT. STANLEY GRZEBIEN, MC, 1st Evacuation Hospital, APO 923, c/o Postmaster, San Francisco, California

CAPT. WALTER E. HAYES, MC, Carlisle Barracks, Pennsylvania

LIEUT. LOUIS D. LIPPITT, to APO 182, Unit 1, 68 Service Group, c/o Postmaster, Los Angeles, California

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CAPT. MARK A. YESSIAN, to 239th Engineers Combat Group, APO 402, c/o Postmaster, Nashville, Tennessee

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LIEUTENANT LOUIS D. LIPPITT, to the rank of Captain

LIEUTENANT (sg) HERMAN MARKS, to the rank of Lieutenant Commander

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THE Committee on Industrial Health of the Rhode Island Medical Society for the past three years has been compiling data regarding industrial plants, industrial physicians and nurses. It has also been analyzing the needs of industry for medical service and helping to bring industry and medicine closer together. The combination of this effort resulted in the Rhode Island Industrial Health Institute held in the Narragansett Hotel last May. Following up on the ground work thus covered the Committee was instrumental in forming the Rhode Island Society of Industrial Physicians and Surgeons.

This Society — it is hoped — will elaborate on medicine's sphere in industry in a manner not possible within the limited confines of the Industrial Health Committee. The purpose of the Rhode Island Society of Industrial Physicians and Surgeons is "to foster the study and discussion of the problems peculiar to the practice of industrial medicine and surgery; to develop methods adapted to the conservation and improvement of health among workers in industries; to promote a more general understanding of the purposes and results of the medical care of employees and to unite into one organization members of the medical profession specializing in industrial medicine and surgery for their mutual advancement in the practice of their profession."

It is sincerely hoped that all physicians and surgeons whose practice is 25% or more industrial will immediately apply for membership. Applications should be addressed to the Secretary, Dr. James P. Deery, State Office Building, Providence, Rhode Island. A program of meetings is planned to be of particular interest to men of industry or those whose practices include a lot of compensation work. Committees will tackle problems which affect industry and medicine, analyzing them and reporting recommendations. Among such problems may be mentioned,

"Medical Service for the Small Plant"
"Women in Industry"
"The Handicapped Worker"
"Rehabilitation and the Problems of the Aged Worker".

Members of the Rhode Island Society of Industrial Physicians and Surgeons will receive the monthly magazine "Industrial Medicine". Affiliation with the American Association of Industrial Physicians and Surgeons is in progress and will probably consummate in the fall. To date the Society has fifty-four members and at the first meeting thirty-four were present. The interest and enthusiasm shown mark this as one of the most active groups in the State and the need for such an organization has been clearly demonstrated.

The officers of the new Society are as follows: Dr. Charles L. Farrell, president; Dr. Richard F. McCoart, Jr., vice president; Dr. James P. Deery, secretary; Dr. Robert T. Henry, treasurer; Dr. Thomas A. Egan, Dr. Frank A. Merlino, Dr. Remington P. Capwell, and Dr. Edward F. Dougherty, members of the board of directors.

R. I. Society of Industrial Physicians and Surgeons — Roster (July 1943)

Drs. Herbert H. Armington, Harold Barrett, Joseph L. Belliotti, Armando A. Bertini, Remington P. Capwell, Leo Cohen, William B. Cohen, E. A. Cormier, James P. Deery, Joseph Doll, Edward F. Dougherty, Patrick A. Durkin, Thomas A. Egan, Charles L. Farrell, George B. Farrell, Francis V. Garside, Albert J. Gaudet, Isaac Gerber, Raymond Hacking, Joseph E. Healey, Robert T. Henry, William H. Hodgson, William A. Horan, Montifax Houghton, Joseph C. Johnston, Harry Kechijian, Natalie Kechijian, John F. Kenney, Stephen A. Kenney, Thad. A. Krolicki, Fiedele Luongo, Nathaniel Maltinou, Earl J. Mars, Morris Marks, Vincent J. Mattera, Edward Medoff, Frank A. Merlino, Walter Molony, Henry B. Moor, Gustavo Motta, Edward A. McLaughlin, Richard F. McCoart, Joseph F. Nourie, Francis D. O'Connell, Joseph C. O'Connell, Vincent Ryan, Carl Sawyer, Lawrence A. Senseman, James F. Sheridan, Stanley Sprague, Benjamin F. Tefft, Malcolm Winkler, N. Darrell Harvey, Joseph Marks.

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FROM THE SECRETARY'S DESK

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July Council Meeting

THE first meeting of the Council under Dr. Michael H. Sullivan, new President of the Society, was held on July 15. Among the important matters acted upon by the Council were the following:

Dr. James L. Wheaton of Pawtucket was unanimously elected to the office of vice-president vacated by Dr. Sullivan, and Mr. John E. Farrell, executive secretary of the Providence Medical Association, was appointed as the executive secretary of the Society, as of July 1.

It was moved that that Council recommend to the House of Delegates at its next meeting that it consider a plan which would provide for membership in the State Medical Society at the same time membership in the district society is granted.

The Council approved of the suggestion of the state director of the Office of Price Administration that it act as arbiter with respect to any flagrant violation of the gasoline use regulations by doctors who are members of the Society.

It was moved to recommend to the Governor that Dr. Harmon P. B. Jordan be named as the representative of the Society on the Special Rhode Island Public Health Laws Survey Commission created by the last session of the General Assembly to study the health laws of the state and its municipalities.

To the Committee on Maternal Health was referred the study of the program for emergency maternity and infant care of the U. S. Children's Bureau through the division of maternal and child health of the State Department of Health, with the recommendation that the committee be authorized to consult with such general practitioners and pediatricians as it may require.

It was recommended that the Committee on Procurement and Assignment serve as an interim War Participation Committee, and that the House of Delegates be asked at its next meeting to empower the President to appoint a War Participation Committee and to establish its duties.

New Members of Society

Dr. Robert L. Bestoso of Newport became the 600th member of the State Society when he was received into membership this past month. Others recently added to the roster are Major Wallace J. Pianka, MC, now stationed at a Pacific war post, Dr. Priscilla Sellman and Dr. John F. Streker, both of Providence.

Milk Commission Meets

The summer meeting of the Milk Commission of the Providence Medical Association was held at the Agawam Hunt on July 14 with many local physicians joining with the producers and distributors of Certified Milk to hear Dr. Woelffer of H. P. Hood & Sons of Boston give an instructive talk on the recent New York meeting, and Mr. Selby discuss the conferences with federal authorities in Washington on the status of certified milk.

Dr. Harold G. Calder, chairman of the local commission, served as toastmaster and introduced Mr. Julian Crandall, who has been collaborating with the Navy in perfecting the manufacture of fishing outfits which are placed in life boats, rafts and planes. The talks elicited many interesting scientific questions.

MEMBERSHIP RECORDS

The executive office plans in the immediate future to send a questionnaire form to every member of the Society to obtain a complete biographical record for the central office files. This information is extremely important as inquiries are being made constantly to the executive office for information relative to doctors in various parts of the State. It is urgent that each member give immediate attention to the task of filling and returning his questionnaire.

A complete war record of the membership, including all activities on the home front as well as the fighting front, is also being compiled. Members are urged to send clippings or items of interest concerning war work of our doctors to the medical library.

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CIVILIAN DEFENSE

JOSEPH C. O'CONNELL, M.D.
State Director, Medical Aid Division, State Council of Defense

OCD — USPH Affiliated Units

At the invitation of the Office of Civilian Defense and the United States Public Health Service, affiliated hospital units, to assist the Army in the event of an extraordinary military necessity in or near Rhode Island, have been formed at Rhode Island and St. Joseph's Hospitals. A unit may consist of fifteen members, including a chief and assistant chief of medical services, two general internists, a chief and assistant chief of surgical services, four general surgeons, two orthopedic surgeons, one dental surgeon, one pathologist and one radiologist. Director of the Rhode Island unit is Dr. George W. Waterman, while Dr. James H. Fagan heads the group at St. Joseph's.

Members of these units receive inactive commissions in the U. S. Public Health Service and will be called to active duty by the Surgeon General only on the recommendation of the Chief Medical Officer of the Office of Civilian Defense. This arrangement will relieve the Army of the necessity for organizing its own special groups of civilian physicians for local emergencies and will help to conserve the dwindling supply of physicians for the civilian population.

Originally the plan called for such units to be organized only at Emergency base hospitals in coastal states to which patients might be transferred from casualty receiving hospitals in target cities under enemy attack. Recently, however, invitations have been extended to 60 institutions in interior States.

Emergency Ambulances

To meet the need for ambulances for emergency demands in the event of an enemy air attack the Office of Civilian Defense has arranged for the distribution of 800 four-stretcher ambulance bodies to cities in target areas. Rhode Island's allotment will be thirteen, of which six will be allowed to Providence.

These ambulance bodies, designed after extensive study, are made of wood and non-critical materials. They can be mounted on the rear portion of the chassis of a Ford, Chevrolet or Plymouth four-door sedan, models 1939-41, after the part of the body behind the front seat has been removed. The ambulances will be roomy enough to carry four stretchers on built-in racks and still leave space behind the stretcher rows for an attendant to ride with the casualties and give the necessary care en route.

Experience in the war has demonstrated that four-stretcher ambulances are essential for the prompt and orderly transportation of the large number of casualties which occur in a major catastrophe, and their use will greatly increase the speed and efficiency with which persons injured in air raids or other major disasters can be transported to hospitals, according to the OCD.

Pamphlet on Burns and Wounds Revised

The Medical Division of the Office of Civilian Defense has revised its pamphlet "Treatment of Burns and Prevention of Wound Infections" to incorporate new techniques that have been developed within the past year. The recommendations in this pamphlet are based on recent directions of the Committee on Chemotherapeutic and Other Agents and the Subcommittee on Burns of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. Originally drawn up by these committees for the armed forces, the recommendations have been modified to adapt them to the problems involved in the treatment of civilian casualties.

Recommendations for the use of sulfonamides are accompanied by the observation that these drugs must be used more cautiously in the treatment of civilian wounds than is necessary in the care of military casualties.

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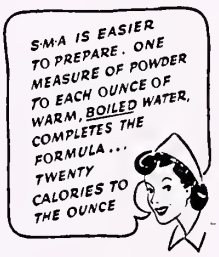
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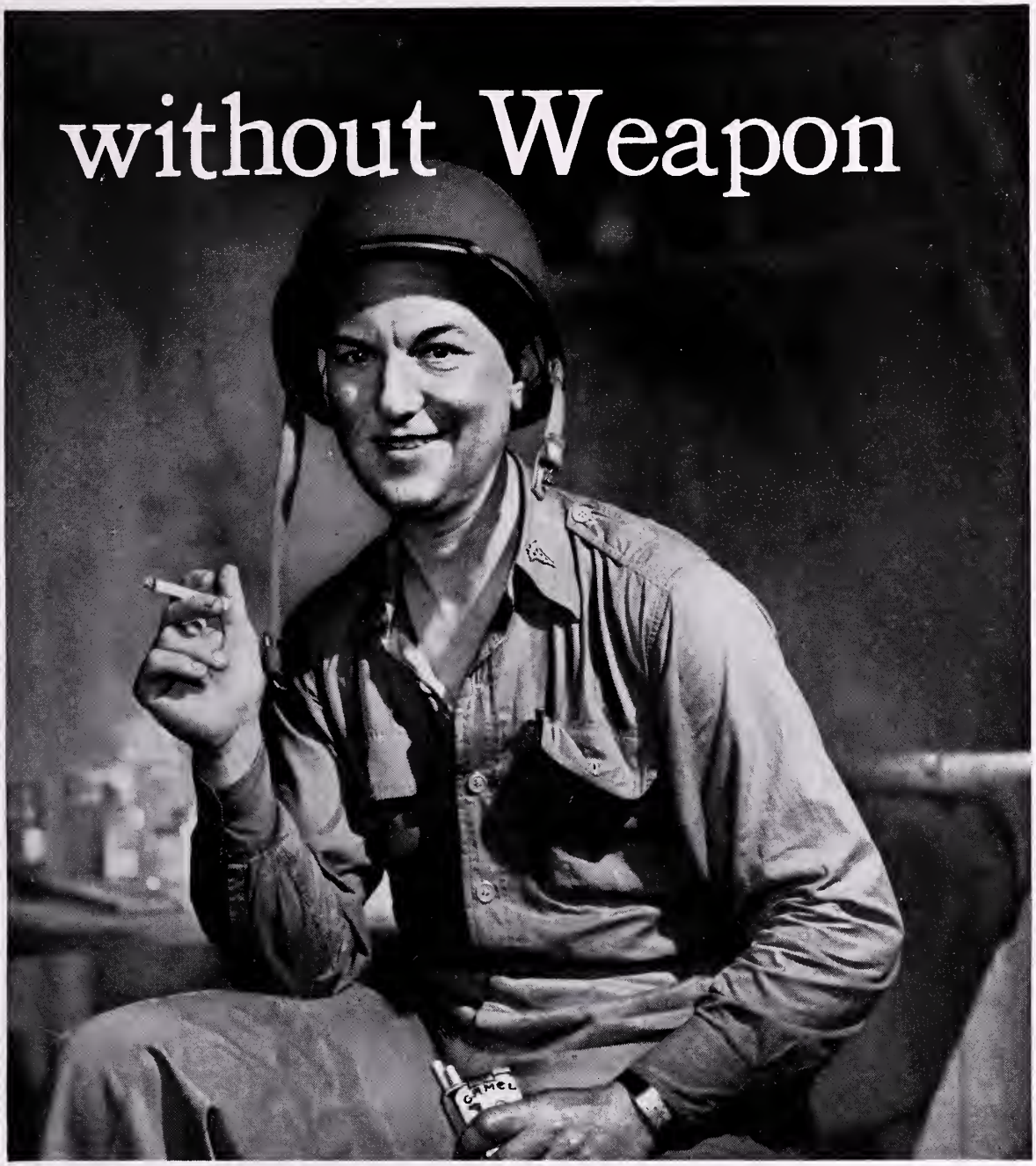
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MASSIVE ARSENOTHERAPY OF EARLY SYPHILIS

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THE TREATMENT of early syphilis by massive doses of arsenical preparations was first attempted by Erlich, but without success. However, the work of Hershfield, Hyman and Wanger[1] in 1931 showed that many such toxic substances could safely be given intravenously by a slow drip method. This prompted Dr. Louis Chargin of the Mount Sinai Hospital to treat early syphilis by an intravenous drip of large amounts of neoarsphenamine. In 1933, he began to treat a series of 25 early syphilitic patients by this method.[2] His work showed that such treatment offered great possibilities in the therapy of early syphilis, and in 1937, Drs. Hyman, Chargin and Leifer began a second series of 86 patients by the same method.[3] Due to the fact that one patient in this series died from hemorrhagic encephalitis and that 38 per cent of the series developed polyneuritis, it was decided to use mapharsen, a less toxic arsenical preparation, in place of neoarsphenamine.

In 1940, the Mount Sinai Hospital group published a report [4 5 6 7 8 9 10 11 12] on the treatment of 270 cases with napharsen by the intravenous drip method. They reported no fatality and no polyneuritis. The encouraging results of this series of cases prompted us to test the method at the Charles V. Chapin Hospital.

Procedure

Our procedure is based as nearly as possible on the method described by Dr. William Leifer.[5] Each patient is given a thorough physical examination and the diagnosis is confirmed by serological tests (Wassermann and Hinton) and if possible, by a dark field examination. Each patient also has a blood chemistry, an icteric index, a complete blood count, and a renal function test (Mosenthal), before treatment is begun. Thus the patients selected for the massive arsenical treatment must be in good physical condition. Elderly patients are not considered suitable subjects for the treatment even though their laboratory findings and physical condition may be good. During the treatment the patient is observed carefully for reactions; his urine is examined daily; and he receives a high carbohydrate, high vitamin diet. In order to develop a uniform technique of therapy and maintain adequate observation, the same physicians carried out the treatment and follow-up of all our cases.

The intravenous solution is mixed in 600 cc. lots which contain 60 mg. of mapharsen in each 600 cc. of 5 per cent glucose in sterile distilled water. The solution is given at the rate of 60 to 90 drops per minute through a 20 gauge needle which has been carefully inserted into a vein on the volar surface of the forearm and securely fixed in place. During each of the five days of treatment, the patient receives 240 mg. of mapharsen in 2400 cc. of 5 per cent glucose solution by continuous drip over a period of about ten hours. He receives a total of 1200 mg. in the five days which is equivalent to twenty weekly routine treatments by the former method of therapy.

Unless a reaction occurs, the patient is allowed out of bed in the evening after each day's treatment has been completed. At the end of the five-day course of treatment, the patient has a complete recheck of the laboratory work which was done before the treatment. He is also kept in the hospital and observed for a period of three to seven days after treatment to be certain that no delayed reactions occur.

Each patient is instructed to return at weekly intervals for the first three months and at monthly intervals for six months or a year, to observe the changes in his serological reaction. He then is rechecked at less frequent intervals for a period of five years, if possible. Each patient has a lumbar puncture before the treatment is started and another about six months after treatment.

The serological examination consists of the standard Wassermann and Hinton tests which are done on serial dilutions of the patient's blood serum and repeated at stated intervals so that changes in the strength of the Wassermann reaction may be followed in each patient. This is used as an index of the regression of the infection in each case.

A group of the patients was given a course of ten weekly intramuscular injections of bismuth salicylate in oil after the intravenous treatment to observe its effect, if any, on the serological response.

In order to eliminate the discomfort of the continuous intravenous drip, the procedure was modified for the last 7 cases in our series. In this group, the mapharsen was given by syringe four times a day for five days. Each dose consisted of 60 mg. of mapharsen dissolved in 15 cc. of sterile distilled water. The patients were encouraged to take 3,000 cc. of fluid a day by mouth to promote adequate excretion.

Cases

We have given massive mapharsen therapy to 68 patients who had primary or secondary syphilis. The group consisted of 34 males and 34 females. There were 31 colored patients and 37 white. The large number of colored patients is interesting in that it is far out of proportion to their number in the community, which is only about 6 per cent. The age of the group ranged between 16 and 56 years, with the majority of cases in the 20 to 30 year group.

Reactions

The most serious reaction to massive arsenotherapy is hemorrhagic encephalitis. Two of our patients developed this reaction, one very severe and the other moderately severe. Both patients recovered after repeated lumbar punctures for spinal fluid drainage and large amounts of hypertonic glucose solution intravenously. It was interesting to note that in both of these patients, the spinal fluid Wassermann was positive during the acute stage of the encephalitis but promptly reverted to negative Wassermann after the acute process had subsided. This may be explained by the fact that a break in the meningovascular barrier has been perpetrated by the chemical encephalitis and allows certain protein elements of the blood to enter the spinal fluid, thereby producing a positive Wassermann reaction without the presence of actual infectious processes in the central nervous system.

Nausea and vomiting were frequent, especially in the female patients. Primary fever was common.

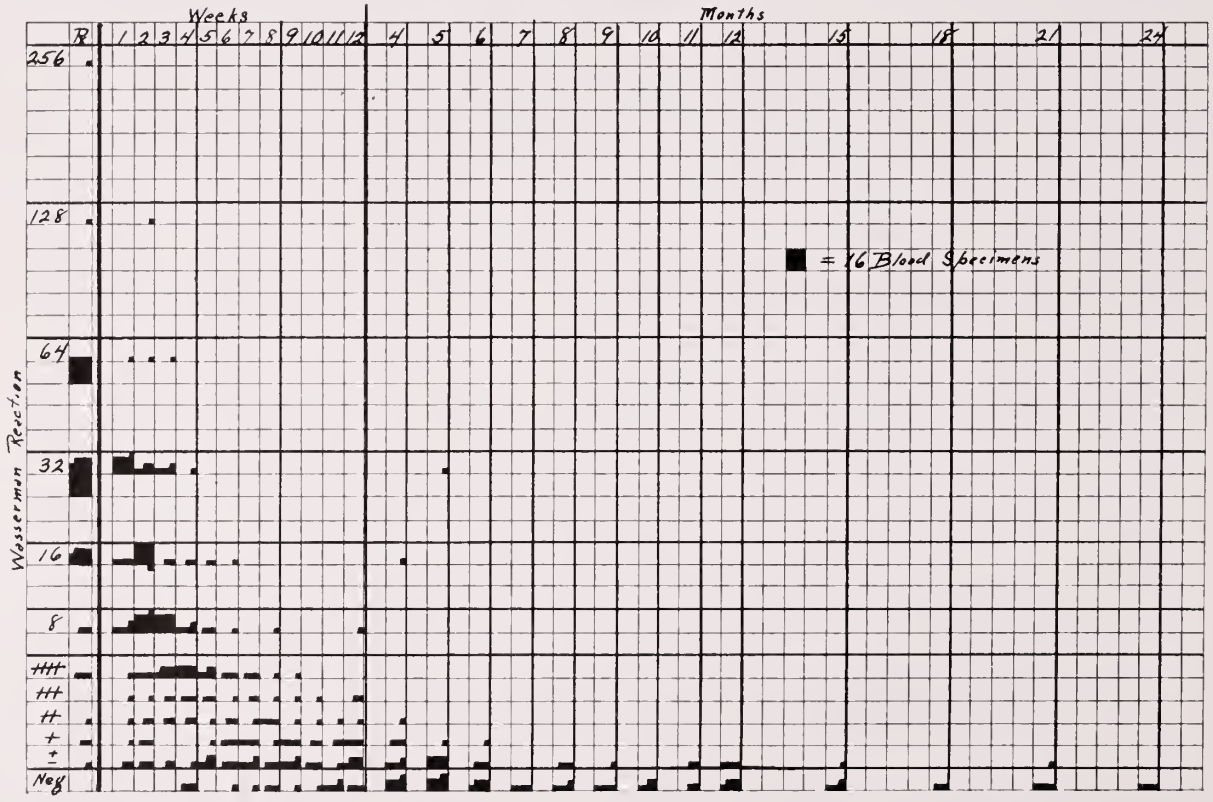


FIG. 2:—*Chart of all the Wassermann Reactions of all patients treated shows the gradual decline in the strength of the Wassermann after treatment.*

Peripheral neuritis occurred only in those who were treated by the continuous intravenous drip method. Figure (1) summarizes these reactions.

FIG. 1: *Toxic Reactions to Mapharsen Therapy in 68 Cases*

	Number	Per Cent
Nausea and vomiting	47	69.1
Primary fever	60	88.3
Secondary fever	3	4.4
Toxicoderma	4	5.9
Dermatitis exfoliativa	0	0
Blood dyscrasias	0	0
Renal damage	0	0
Jaundice	0	0
Peripheral neuritis	7	10.3
Hemorrhagic encephalitis	2	2.9
Single convulsion	0	0
Disorientation	1	1.5
Fatality	0	0

Although there has been no fatality in this series of 68 patients, the possibility of such an event is ever present. Therefore, due consideration must be taken before a patient is given the treatment, and it should be given only in a hospital where facilities are adequate for preliminary examination and careful observation.

Results

In this series of 68 patients who received massive mapharsen therapy, 18 patients have been followed for one year or longer, with a maximum follow-up of two years in 4 cases. The six month follow-up was obtained in 29 cases. Eight cases which were treated less than six months previous to this report have been disregarded in computing all results. Cases which did not return for follow-up have also been discarded after their last visit.

The Wassermann and Hinton reactions on the blood of 50 per cent of the cases followed had become negative at the end of five months after treatment, and 80 per cent had become negative at the end of nine months. As is evident from the chart (Fig. 2), the serological reaction does not become negative immediately after treatment, but slowly becomes weaker over a period of months which depends upon the strength of the original Wassermann before the treatment was given.

Dividing the series into a group of 20 cases which received only mapharsen and another group of 40 cases which received, in addition, a series of 10 weekly intramuscular injections of bismuth, the only significant difference in results is that the Wassermann became negative more rapidly in the group receiving bismuth (Fig. 3). There was no significant difference in the percentage of negative Wassermanns in the two groups when nine months had elapsed after treatment.

The blood Wassermann and Hinton reactions eventually became doubtful or negative after one course of treatment in all of the cases that have been followed, with one exception. The exception was a female whose serology became negative eight weeks after treatment and then showed a progressively stronger reaction at three, four, and five months. At the latter time, she developed a secondary rash again and was given a second course of treatment. Due to the fact that no primary lesion could be found, this case must be regarded as a failure of treatment.

One patient was treated during the sixth month of pregnancy without any bad effects on the mother or fetus. She subsequently delivered a normal, full-

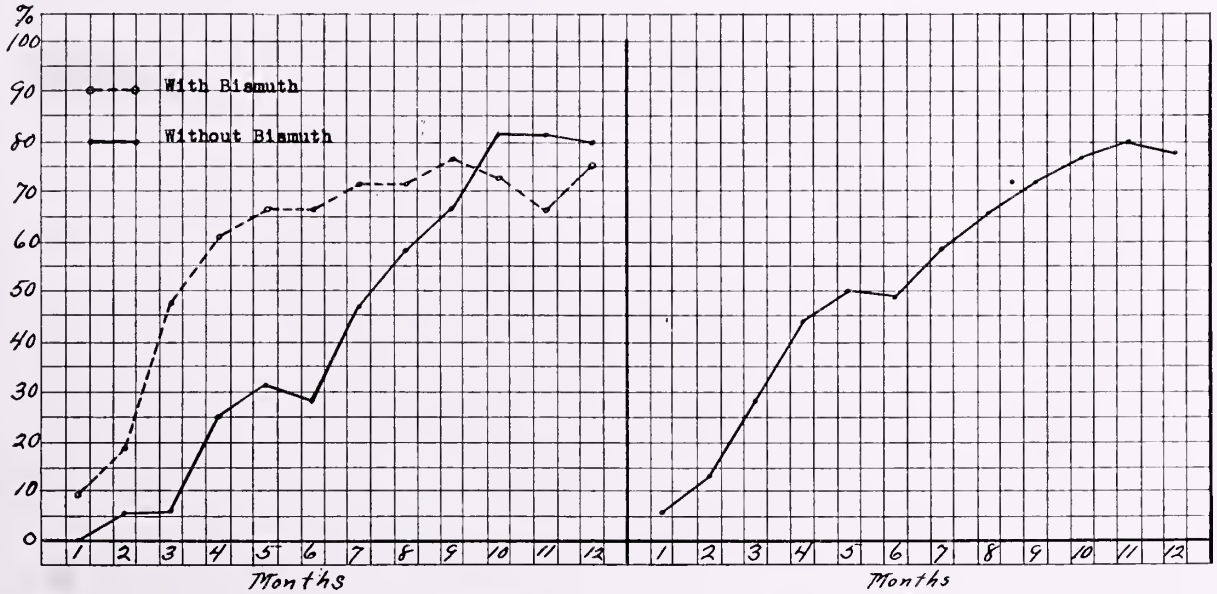


FIG. 3 *% of Cases Reaching Negative Wassermann* *% of All Cases Reaching Negative Wassermann*

term infant whose Wassermann was negative and who showed no evidence of congenital syphilis.

Lumbar puncture examinations were made on 26 cases at an interval of at least six months after treatment. The spinal fluid was found to be completely negative in all of these cases.

Summary

A series of 61 patients was given massive mapharsen therapy for primary or secondary syphilis by the continuous intravenous drip method and 7 by the syringe method. There were no fatalities and only 2 cases of severe hemorrhagic encephalitis. The latter occurred in the group which received the continuous drip method. There was only one failure of treatment, which gives a rate of cure of 94.7 per cent in the 18 cases followed for one year.

Conclusions

1. Our series is too small and the follow-up period too short to make definite conclusions regarding the effectiveness of this form of treatment.

2. From this series of cases and those already reported in the literature, it may be concluded that massive arsenotherapy of early syphilis is a relatively safe procedure if it is carried out in a hospital, if the cases are carefully selected, and if they are closely observed during treatment and for several days following treatment.

3. The follow-up of the patients is important in order that a proper estimate of the effect of massive arsenotherapy can be obtained. It is a difficult task and requires the interest and cooperation of the physicians and social agencies together with the venereal division of the Board of Health to locate and encourage patients to return for examination at intervals over a prolonged period of time.

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LIEUT. EDMUND SYDLOWSKI, MC, to Carlisle Barracks, Pa.

LIEUT. (jg) F. P. VOSE, MC, USNR, to Dispensary, Portsmouth Navy Yard, Portsmouth, N. H.

TRANSFERS

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PROMOTIONS

LIEUT. SEEBERT J. GOLDOWSKY, MC, to the rank of Captain.

CAPTAIN LAWRENCE A. MORI, MC, to the rank of Major.

THE LUXURY OF SOCIAL INSURANCE

JARVIS FARLEY

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THERE is general acceptance of the principle that no social security program can work satisfactorily unless there is relative stability of employment. There is considerable difference of opinion, however, as to the methods by which we may hope to minimize unemployment. Most of the outspoken advocates of formal social programs give the impression of being advocates of a high degree of government control of, and participation in, the economy. The statements of such advocates seem to imply broad government control, wide government planning, and effective enforcement of government plans, which in turn—despite the phrases used by the planners—mean the end of any hope of free private enterprise.

That is a serious thought, because no system can match free enterprise in the standard of living which it can create and in the effectiveness of the social security measures which it can support. Thus it is necessary to define the economic assumptions before there is any point in discussing the details of social measures to supplement the normal distribution machinery of the economy. We should set our goal at the highest level. We should not be content with a merely satisfactory degree of social security or with an economy which is merely workable. We should not be satisfied with anything less than the highest degree of social security and economic efficiency which we can practically hope to attain.

National Economy and Social Budgeting

There is a sort of progression of the relationship between a nation's economy and its attitude toward social budgeting. When a community—using that word in the sense of an integrated economic group, whether it be tribe, city or nation—is very young economically it lives a hand to mouth sort of existence. All the effort of its members is needed to feed and clothe themselves and to sustain a relatively low standard of living, and there is little or no margin for savings or for luxuries. In that stage of economic progress unproductive members may be disposed of or they may be allowed to hang around to glean subsistence from the leavings of the others. Such a community can scarcely give much thought to social insurance.

As enterprising individuals are able to forego the current consumption of some part of their efforts—that is, to save—they create the beginnings of a capital investment which can be the means of increasing the effectiveness and productivity of their labor. The community is the gainer thereby, the standard of living improves, and as they get a toehold in the process of capital accumulation they are able to develop a wider margin between their productive capacity and the minimum subsistence level. From this margin they can improve their standard of living or they can accumulate more capital or they can pay more attention to the plight of the unfortunate, unproductive members. Probably they will do some of each. In this stage individual charity emerges, and as the stage develops there may be organized private charity and even some minimum form of public assistance. In this stage, however, every increment of saving that is used to improve the lot of the unproductive is not available to add to capital resources, and the self-interest of the productive majority will see that the relief measures are relatively low in order not to impair the accumulation of the capital which is to be the foundation for the more abundant life tomorrow. The process may not be consciously reasoned out, but that is the effect of the natural motives.

Throughout the entire progress of the community the condition of the unproductive members is in rather direct proportion to the general margin over subsistence which the productive organization of the economy allows. As the margin widens, the standard living of every productive member is raised (the lowest is probably raised more, relatively, than the average) and more and more attention is paid to the unproductive members. Organized relief comes as a marked improvement over unorganized charity, but the needs test plays a big part in order that the community's saving power may still be conserved to expand the capital resources and not be dissipated in payment to those who are not in actual need.

Reaching the Final Stage

In the final stage of economic progress the capital accumulations of the past and the efficient productive organization of the present bring the productive margin so far above the subsistence level

that the community can afford substantial luxuries. Nearly everyone has extra material comforts and leisure in which to enjoy them. The existence of a substantial capital backlog removes pressure for new saving for investment. New investment has progressed far toward the point of diminishing utility and the community's capacity for saving can be turned in larger measure to current enjoyment and toward improving further the lot of the unproductive. At this stage in economic progress, when the community has a high capital investment and when the productive machinery is operating efficiently, the community can put into practice its ideals of social insurance; the needs test can be eliminated and presumptive need substituted as the test of the right to receive benefits. The community can afford a complete formal program of social security, and in all probability will establish such a program.

The final stage will be reached only if the economy is efficiently productive—and it cannot be held except by sustaining that efficiency. If at any time during that economic progress anything happens to impair the community's productive efficiency the result will be a cutting down of the margin over and above the subsistence level. Any reduction in that margin would mean an increase in pressure for savings or for current consumption and a decrease in the community's capacity or inclination to support its unproductive members. If the program which the community adopts at the top stage of its economic development has in it factors which impair the productive efficiency of the economy that margin will be reduced. If the impairment continues the community may reverse its economic history and step down from stage to stage until its ability and desire to care for unproductive members is largely destroyed.

Such a downward trend would not be the orderly result of a reasoned decision by the community to reverse its social program and to reduce its attention to unproductive members. An electorate does not easily give up benefits to which it feels entitled. The reversal of procedure is apt to be quite disorderly, accompanied by declining living standards and increased unemployment, with all the dangerous social and political implications of serious economic unrest. The emergence of mass unemployment would impose severe and possibly unbearable strains on the social insurance system; and the attempts to meet those strains might have most serious effects on our economic and political structure.

Importance of Timing Social Measures

The timing of our social measures is important to the economic relationship. We have already committed ourselves to heavy cost burdens in winning this war, and we cannot avoid further heavy costs in implementing the peace to follow. The process of restoring our civilian economy and of preparing to utilize for peace the new inventions and developments of wartime will require substantial capital investments, which can be made only by foregoing the current enjoyment of a part of our current production. The costs to which we are already committed will make inroads into the amounts available for current consumption. The greater our commitments the less will be left for current use; and further commitments would mean a corresponding decrease in our living standards. This end is reached whether we meet our commitments by voluntarily reducing our consumption or by reducing the amounts which we save—for inadequate saving for capital investment will reduce the productive efficiency of our economy. There is a limit to the cuts in living standards which we can accept without serious social and political unrest, and we must be careful not to commit ourselves beyond that limit. Social security is one such commitment, and impatience for results, by extending the program before we have the capacity to support it, can carry us into serious economic, social and political disorders just as surely as direct interference with the economy.

Economic and Social Philosophy Inseparable

For these reasons economic philosophy and social philosophy cannot be separated. A sound economy can make possible the highest development of social budgeting, but an advanced stage of social budgeting cannot exist without the sound economy. The economy must come first and the economy must be sound. Problems of distribution are important when productivity is high, but when productivity is lowered and there is less to distribute the problems of the unproductive lose their importance in the eyes of the productive voters. That is why social insurance cannot be considered by itself but must be related and subordinated to economic considerations. That is why we must have a sound economy of free private enterprise before we can afford the luxury of social insurance, because only the free economy can be efficient enough and productive enough to reach the final stage of economic development. We have been very near to having such an economy. We do not have it now and we will not have it after the war if social plan-

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ESSENTIALS OF THE DIAGNOSIS OF HEART DISEASE

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THERE ARE several reasons why a diagnosis of heart disease should be made only when the evidence thoroughly justifies the opinion that damage has occurred or is occurring in the heart. Not the least of these reasons for diagnostic accuracy is the fact that laymen think of heart disease as a more or less hopeless condition, refractory to treatment and leading to early heart failure and sudden death. The profession is well aware that these fears are apt to be groundless, that sudden death occurs in a very small percentage of patients, that heart failure is often successfully relieved and that many patients with serious disorders of the cardiac apparatus may be so supervised as to live a normal length of life. The public is not well aware of these truths although increasing attempts at education through the press and radio are being made. As in almost all diseases early recognition of the difficulty is important; many patients have organic heart disease but are free of symptoms for years, later to succumb to rapidly progressive failure; in these patients early diagnosis, before the onset of symptoms, with the application of preventive restrictions frequently serves to postpone disability. Patients in this category can usually be truthfully told that intelligent management will add to their span of productive and comfortable years.

There are a few rather common erroneous ideas about certain diagnostic criteria: among these are the misconceptions that a heart is sound if it lacks murmurs, except in the presence of irregularity and rapidity which is taken to be indicative of myocardial damage, and that any of the so-called cardiac symptoms such as shortness of breath, edema and precordial pain indicate heart disease. It is well to emphasize that there are no absolutely pathognomonic SYMPTOMS of heart disease with the possible exception of classically typical episodes of angina pectoris and coronary thrombosis.

The data which we assemble in connection with the chief complaints, past illnesses and family history are of use but only as supplements to the main evidence. This is illustrated by the patient with a cardiac neurosis who may present the typical symptoms usually associated with cardiovascular disease but which on occasion may be non-cardiac in origin, as, for example, the dyspnea which is due to pulmonary lesions or to severe anemia, or the peripheral edema due to the local circulatory stasis of varicose veins or to the low serum protein level of malnutrition, or to nephritis, nephrosis and vitamin deficiency.

There are certain SIGNS that are pathognomonic of heart disease and are detectable without recourse to laboratory methods. These have been described so repeatedly by various authors that knowledge of them should be general. Various sources have been freely drawn upon in listing these signs.* To compile a list of pathognomic items of objective evidence implies a certain amount of dogmatism which is necessary in order to define the rules which will hold true in a majority of cases. In general any one of the items on the list may be accepted as reliable evidence of heart disease, and the absence of all of the items may be considered as proof that organic heart disease is not present. With the exception of electrocardiography the precise methods of cardiovascular investigation will add merely confirmatory evidence. There are rare exceptions to this, as, for example, the patient recently observed in whom the diagnosis of a persistent right-sided aortic arch could be made only by the roentgen ray picture. It is recognized that subtle and sometimes serious abnormalities may be discovered only by electrocardiography, nevertheless, for all practical purposes these ten criteria may be accepted, each in itself, though rarely present singly, as sufficient evidence to establish a diagnosis of heart disease, as follows:

1. Cardiac Enlargement.
2. Persistent Hypertension.
3. Marked Generalized Arteriosclerosis.
4. Diastolic Murmurs and Palpable Thrills.
5. Engorgement of the Neck Veins and Abnormal Pulsations.

*In particular, Chapter I, Synopsis of Diseases of the Heart and Arteries. George R. Hermann, C. V. Mosby Company 1941.

6. Gallop Rhythm.
7. Serious Disorders of the Cardiac Mechanism.
8. Dilatation of the Aorta.
9. Abnormal Retro-manubrial Dullness.
10. The Coronary Thrombosis and Angina Pectoris Syndromes.

I. Cardiac Enlargement.

Enlargement of the heart, the result of hypertrophy or dilatation or both, indicates heart disease whenever it is sufficient to be detected by physical examination. The most reliable evidence of hypertrophy is the position of the cardiac apex. When this is outside the midclavicular line to the left one can feel certain that the heart is enlarged unless there are thoracic pathologic conditions which cause displacement. The fundamental stimulus to the production of hypertrophy is the cardiac dilatation which results from strain, as from overwork caused by a stenotic valve or by hypertension. When heart muscle cells become enlarged the capillary distribution to them is proportionately less and the speed of oxygen diffusion to them is diminished. Under such circumstances more time is required for recovery of the heart muscle cells after systole, consequently such hearts must beat slowly or failure will ensue more or less rapidly.

II. Persistent Hypertension.

It is not necessary to say much about hypertension as evidence of cardiovascular disease. For this purpose it is sufficient to state that in persistent hypertension changes occur in all the arteriolar beds, particularly in the heart muscle, the brain and the kidney. The hypertensive state imposes an increased load on the heart; left ventricular strain is inevitable and left ventricular failure is a common result.

III. Marked Generalized Arteriosclerosis.

Marked general arteriosclerosis evidenced by peripheral signs usually involves also the aorta and the coronary arteries to such an extent that it seems reasonable to conclude that heart disease is present. The absence of demonstrable arteriosclerotic changes in the peripheral arteries does not mean that the coronary system is normal since it may be predominantly involved. Likewise there may be predominant involvement elsewhere without generalized spread, as, for example, the markedly calcific vessels in the lower leg which are often found by x-ray in a symptomless patient. Although arteriosclerosis may exist as a patchy phenomenon it is safe to assume that when it is demonstrable in several areas it probably is generalized. Arteriosclerotic coronary artery disease inevitably impairs the structure as well as the function of the myocardium.

IV. Diastolic Murmurs and Palpable Thrills.

Thrills, both systolic and diastolic, may always be accepted as pathognomonic of disease. Diastolic thrills are usually accompanied by diastolic murmurs but the reverse is not necessarily true. A pronounced diastolic murmur of mitral stenosis is usually accompanied by a palpable thrill whereas in aortic insufficiency a thrill is usually absent.

Distinct systolic thrills are the palpable counterparts of loud systolic murmurs and are quite significant. Occasionally an overactive but otherwise normal heart produces a vibration of the precordium which simulates a systolic thrill. Many apical systolic murmurs are the result of a relative dilatation of the mitral ring rather than the sequellae of true valvulitis. Systolic murmurs may be entirely extra-cardiac in origin. A systolic thrill or murmur in itself cannot be included in the list of reliable diagnostic signs but certain systolic murmurs and thrills are significant. A thrill and murmur over a peripheral artery suggests arterio-venous aneurysm. A systolic thrill and murmur over the base of the heart to the left with diminution or absence of the pulmonary second sound are usually due to congenital pulmonary stenosis. A similar thrill and murmur maximal in the midsternal region with greatest transmission towards the right often indicates a congenitally defective interventricular septum. Similar findings in other locations suggest other congenital lesions. A systolic murmur and thrill in the aortic area especially in the presence of a slow, plateau-type of pulse, with a diminution in the aortic second sound, indicate aortic stenosis.

V. Engorgement of The Neck Veins and Abnormal Pulsations.

Engorgement of the neck veins, especially when they remain full with the patient in the upright position, usually indicates heart disease and is due to the increased venous pressure which accompanies weakness of the right ventricle with the back pressure phenomenon of congestive failure. Occasionally engorgement of the neck veins is the result of local stasis in the superior vena cava by abnormal pressure in the mediastinum. When engorgement of the neck veins is due to congestive heart failure there are other evidences of venous stasis to be found in other parts of the body ordinarily, such as edema, engorgement of the liver and cyanosis.

Abnormal cardiac pulsations in the left anterior axillary line in the fifth interspace may be taken as evidence of enlargement of the heart; when pulsations are present in the precordial area they are usually due to abnormal activity of a dilated right ventricle or to impingement of the pulmonary conus against the anterior chest wall by reason of right ventricular hypertrophy. Enlarged and tortuous intercostal arteries may occasionally produce visible and palpable pulsations. Sources of error are the abnormal situations of the cardiac apical impulse due to displacement of the heart by fluid or air in the right chest or by atelectasis and collapse of the left lung. More rarely there may be precordial and parietal adhesions involving the root of the aorta with consequent abnormal pulsations.

VI. Gallop Rhythm.

Marked gallop rhythm is a reliable sign of myocardial damage, usually the result of intrinsic disease of the left ventricle or both ventricles, but may be produced by severe anemia and by prolonged infection. Gallop rhythm consists of three distinct heart sounds occurring with each cardiac contraction, usually at a heart rate increased above normal. Above the rate of 80 and especially above 100 the treble sounds resemble the galloping beats of horses' hooves. Below a rate of 80 the same three sounds have largely lost the resemblance to a gallop. Two of the three sounds of gallop rhythm are the normal first and second sounds of the heart, the third sound is the unusual one and may be of various origins. When it comes just before the first sound it is called presystolic gallop rhythm. Most often it comes shortly after the second sound, producing the proto-diastolic gallop rhythm. Sometimes it comes between the second and first sounds and is known as the meso-diastolic gallop rhythm. Rarely it comes during systole to be known as systolic gallop rhythm. Accurate differentiation of these types is frequently impossible. The mechanism giving rise to presystolic or proto-systolic gallop rhythm at relatively slow rates may produce the opposite type at very fast rates. Thus the simple designation "gallop rhythm" may suffice for most purposes. The proto-diastolic gallop rhythm is actually much more common than the others.

Although the mechanism of the production of the abnormal third sound is not definitely known it does accord in time with the normal third sound of the heart and there are other reasons for presuming that this abnormal sound is, as a rule, a much accentuated third heart sound. A simple physiological increase in the mechanism of the third sound production may be found normally after exercise or with the excessive heart activity of neuro-circulatory asthenia, and is explained by rapid dilatation of the ventricles with very forceful flow of blood from the auricles, which is accompanied by an opening snap of the mitral valve and a rebound of the blood from the ventricular wall. Proto-diastolic gallop rhythm is frequently heard in mitral stenosis in which case it is possible that the stiffness of the diseased mitral valve produces the third sound by its vibration early in diastole.

The most common and important condition in which gallop rhythm is found is cardiac weakness and dilatation especially that of the left ventricle; the gallop rhythm may or may not precede actual signs of failure. The mechanism of the third sound in this condition is probably that of the transmitted shock against the wall of the dilated ventricle caused by the rushing in of the blood stream from the engorged auricle under considerable pressure early in diastole. This explanation is supported by the fact that one of the most striking signs which accompanies and coincides in time with the third heart sound is an additional cardiac impulse against the chest wall in the region of the apex; sometimes this impulse is more pronounced than the third sound itself.

All of the diastolic gallop rhythms have essentially the same significance but systolic gallop rhythm is unimportant. The extra sound is apt to be a click or a snap different from the normal heart sounds and its cause is unknown; perhaps it is due to deformities or defects of valves or cordi tendiniae, of pericardium or pleura. Often gallop rhythm disappears during digitalis therapy only to reappear later if the drug is omitted or if myocardial weakness becomes more pronounced. Gallop rhythm is less significant in the presence of bundle branch block, atrio-ventricular block, mitral stenosis, aortic insufficiency and hypertension. Nevertheless, its presence justifies the diagnosis of myocardial disease. Gallop rhythm must be differentiated from the third heart sound of adolescence and the uncommon sounds sometimes produced by chest deformities.

VII. Serious Disorders of The Cardiac Mechanism.

Important arrhythmias such as auricular flutter, auricular fibrillation, heart block et cetera are so very rarely present in normal hearts that their presence may be taken as evidence of heart disease.

In this category also is placed pulsus alternans which is usually detectable only while taking the blood pressure but in the most extreme cases shows definite alternate weak and strong beats in the palpable arteries. Disturbances of the mechanism with regular rhythm, such as paroxysmal auricular tachycardia often occur in normal hearts and should not be taken as definite evidence of heart disease.

VIII. Dilatation of The Aorta.

In the absence of hypertension an abnormally accentuated ringing aortic second sound, especially when there is also an aortic systolic murmur is indicative of dilatation or sclerotic pathological changes, or both, in the vicinity of the root of the aorta. This sign is often due to luetic aortitis and also occurs from simple degenerative changes about the aortic ring, sometimes involving the orifices of the coronary arteries. Confirmatory evidence of aortic dilatation by the roentgen ray can usually be obtained.

IX. Abnormal Retro-Manubrial Dullness.

Conspicuous abnormal dullness beyond the borders of the sternum at the base of the heart and increased palpability and visibility of the aortic pulsations in the supra-sternal notch usually signify pathologic processes involving the aorta, which excluding aortic aneurysm located well away from the ascending aorta, are apt to involve the circulation of the myocardium itself through diminution of the coronary flow.

X. The Coronary Thrombosis and Angina Pectoris Syndromes.

Angina pectoris and the coronary thrombosis syndromes constitute irrefutable evidence of heart disease and either one of these, when clearly typical and in the absence of other signs, must occasionally be accepted as the *only* evidence of heart disease.

In general, heart disease may be diagnosed if one of these ten criteria is present. Usually, however, there are several corroborative findings. When none of these can be found there is reasonable certainty that significant heart disease is not present. In the absence of all of these signs cardiac symptoms must be considered as a part of functional rather than organic heart disease.

LUXURY OF SOCIAL INSURANCE

continued from page 158

ning has its way. Too much government regulation and government participation in the economy can impair its productivity to a point where the community will no longer be willing to consider the luxury of social insurance. Therefore the order, both in time and importance, must be first a sound efficient economy, and second the program of social insurance; and any attempt to reverse that order will defeat itself.

Today we are in a position very much like that of two hundred years ago. There are influential groups who would have our government put too much weight on its own economic influence and not enough weight on the constructive forces of natural human instinct. Two centuries ago the barriers which government imposed against normal incentives held down economic development until the barriers were broken by the forces of which Adam Smith was the intellectual spearhead. The breaking of the barriers made possible the Industrial Revolution and tremendous increases in the living standards of all. In recent years our economic development has again been hampered by artificial government-imposed barriers. Some of them, like tariff walls, have been imposed at the insistence of business men themselves, but they are none-the-less harmful. We cannot return to a laissez-faire economy; we do not need to do so. Continual government policing is necessary. It is the widespread government intervention in business policymaking and business administration—as distinct from policing—which can bring unfortunate results. Not until we have less government intervention in these respects, rather than more, will society be able to realize the potentialities of free private enterprise. If that time comes, if we successfully shoulder the burdens of post-war reconstruction and readjustment, if we establish the atmosphere of reasonable confidence and understanding between the leaders of labor and management which alone can restore the political feasibility of rebuilding our economy around the profit motive, then we can approach the problems of social insurance with real hope of building a sound social security program. Unless we can do those things to a reasonable degree there is not much basis for optimism toward our future.

We *can* do them. Wartime hardships can restore to our nation and to the world a sense of values which was lost in the years before the war. We are about to enter a period of public discussion which can lead to reasonably sound decisions on the economic issues; and the urgency of the times can bring forth leaders capable of carrying out those decisions. The soundest statement in the Beveridge Report appears in the last paragraph: "Freedom from want cannot be forced on a democracy or given to a democracy. It must be won by them."

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The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society,
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SYPHILOPHOBIA

FOR AT LEAST a generation we doctors have had it drilled into us that syphilis is of frequent occurrence and a great menace. We have been told of its protein manifestations and taught to suspect it in all unusual conditions.

Cancers of the mouth have had delayed treatment while tests were made for syphilis or treatment for the latter was carried out when there was positive serology. One surgeon was accustomed to keep all hemorrhoid cases filling ward beds until negative Wassermanns were obtained. A striking case presenting symptoms of bile obstruction was given treatment with heavy metals for years because of congenital lues. Finally when the liver was well ruined operation showed there had been obstruction.

Of recent years a national hue and cry has convinced the public of the great prevalence and grave danger of this plague. It has been written up in the lay press as much or more than in the medical publications. As a result the hunt for the treponema pallidum has assumed immense proportions. Not only does every youngster called up to the armed forces have to give his blood but every nice boy and girl wishing to marry have to "prove" that they are immaculate in this respect.

Now it is well worth while that syphilitics shouldn't marry. No more (to reach for ideals) should mental defectives, the tuberculous, or the vast number with various types of nervous troubles. Why not before the marriage license is issued demand an I. Q. test, X-ray of the lungs, and a mental hygiene examination?

The answer in the opinion of many is our national tendency to overemphasis. We have whooped up the syphilis scare with a din comparable to our fire sirens which are seldom silent in our cities.

Most of us have wondered why in our practice we have not encountered the syphilitic scourge we have been told about. As we have run hospital services and taken routine Wassermanns, lues has still been not in great evidence. We have been told by the physician in charge of the health of a large university that in many years, with thousands of students, he has had reason to believe that this disease has been almost non-existent there.

And why such a small harvest when we have been authoritatively told of such a large planting? Smillie in the Journal of the A. M. A. has given a good answer. It is largely the old story of the misinterpretation of statistics, "Syphilis in the U. S. primarily a negro problem." Florida with a large negro population has a syphilis rate of 5.3% in white men, 40.6% in negroes. Rhode Island, 0.9% in white, 9.2% in negroes. Dr. Bell in his article in this number of our JOURNAL, written before

Smillie's article had appeared noted that with 6% of our population black his series of syphilitic cases were practically 50% negroes.

Smillie says, "These data show that most of the popular propaganda that has been used in promoting syphilis control in the U. S. has been highly misleading. 'One person in ten will have syphilis' is a popular saying but it is untrue. The incidence of syphilis among white men in the greater part of the nation is low and is limited for the most part, in the white race, to the lowest classes of society."

Are the faces of some of our Health leaders red? Once again they have done their best to make skeptics of us all. Human energies and money are limited, war statistics to the contrary notwithstanding. If we waste our strength in one direction we will inevitably let up in another. Let's get realistic about syphilis.

SOCIAL INSURANCE

In this issue of the JOURNAL there is published an excellent study of the underlying factors involved in social insurance. We commend the article to your reading for when Congress reconvenes this month there will undoubtedly be much discussion of the Wagner-Murray-Dingell act which spread its extensive program on the legislative records last June.

On the one hand there is certain to be pressure from social security planners as they outline an over-all scheme for the masses which presumably will end want. Support of the Wagner measure has already been announced in the press by labor leaders whom we suspect are happily looking to the expansion of social security as an easy solution of their problem instead of facing their real task of finding employment at fair wages for the returning soldiers, as well as for the citizens at home who have been dislocated by the war effort.

From clear thinking business and professional leaders, on the other hand, should be forthcoming sound counsel to guide our Congress lest the initiative which has made this country great be stifled, and lest the sound economy upon which any successful program is established be overlooked. It may be more blessed to give than to receive, but we suspect that the principle of charity is not the motivating force of the social planners.

We can point to no better example of the desire of the American people to solve their own problems to their own satisfaction than the growth of the Blue Cross hospital service in Rhode Island. Here is a non-profit organization which borrowed funds to start its work four years ago, which carried on its program with a minimum of salesmanship and advertising, and which today has an enrolment of more than one-fifth of the population of this State!

The soundest statement of the Beveridge report was indeed the one that "freedom from want cannot be forced on a democracy or given to a democracy. It must be won by them."

HOLMES AND IRVING

In a recent number of the *New England Journal of Medicine* Frederick C. Irving has an article on Oliver Wendell Holmes and Puerperal Fever written in the delightful manner familiar to the readers of Safe Deliverance.

This year is the anniversary of the paper which so authoritatively summed up the facts proving the nature of this disease. We hope many physicians will be moved to read or reread this article of which all knowing Americans are so proud.

In those days "folks liked their doctors musty like their cheese." This explains why Holmes was not a successful practitioner even though with him "small fevers were gratefully accepted." He could write The Chambered Nautilus and The Autocrat of the Breakfast Table. For years his lecture room at the Harvard Medical School was filled with visitors to his regular classes, come there to hear the whimsical way in which he could make even the dull facts of anatomy charming.

He could not write even a scientific paper on a loathsome disease without making it pure literature or even poetry—

> "Where facts are numerous and unquestionable and unequivocal in their significance, theory must follow them as it best may, keeping time with their step, and not go before them, marching to the sound of its own drum and trumpet."
>
> "No man makes a quarrel with me over the counterpane that covers a mother with her newborn infant at her breast."
>
> "We do not deny that the God of battles decides the fate of nations; but we like to have the biggest squadrons on our side, and we are particular that our soldiers should not only say their prayers, but also keep their powder dry."

One more quotation and we are through. Even a letter to a casual acquaintance would be certain to have a pleasing fantasy. This is in our possession—

> Dear Dr. —
>
> I have made up my mind that I must and will have rest from excitement and overwork. Old

doctors, old poets and old men are getting scarce and though the one I have charge of is among the least important, I find he is worth my caring for a little longer. And as he is very tired just now, I order him to keep absolutely quiet for the present.

Yours very truly,

O. W. Holmes

Dr. Irving, dwelling in Dr. Holmes' Boston, is the same rare combination of physician and literary man.

SIGN HERE, DOCTOR!

Additional fuel oil? Have your doctor sign . . . oh, it is gasoline you wish for a motor trip for your health. No matter—just have your doctor sign special form 3784x. Perhaps you are short on your vitamins, or orange juice doesn't agree with you? Well, why don't you get a doctor's certificate and take it to your ration board so that you may get more red points for meat, or blue points for canned pineapple juice? You're tired and would like a rest? Didn't you know that you can get sickness insurance benefits while you are out ill? All you need is a certificate from your doctor. Or perhaps your job doesn't agree with you when you know you can get more money elsewhere. In that case you can get clearance if you show your present work is injurious to your health. Get a certificate from your doctor. What do you mean you can't get a certificate from your doctor? Do you mean to say that he has enlisted in the Army and is with the forces invading Sicily? He can't do that to you. Your health is important, and besides you have got to get a doctor's signature these days to get anything!

MIDDLE CLASS AMERICA

To attempt a practical application of tax policy and Government spending to the middle class American, let us consider the American medical profession as a part of our economy.

We all know that the emergency of illness is one of the worst hazards of the family of average means. Proposals for Government-supported medical services can therefore be dressed most effectively "in the language of the true humanitarian."

It is not difficult for any of us, now that the Treasury Department has recommended an increase of $12 billion in the tax load, to imagine an income tax for the average American family which might make payments for private medical service impossible.

There is now pending in Congress a proposal for the Government to spend more than $3 billion on medical and hospitalization service.

That $3 billion is a quarter of the tax increase sought by the Administration. So with the one hand the Government would take away from the middle class American his ability to provide private medical care for himself and his family, and with the other it would offer him Government hospitalization and medical care.

Physicians in private practice would find their incomes from private sources at the vanishing point. They would have to seek Government employment. Thus, in this vital matter of hospitalization and medical care, the individual American, as well as the professional man, would be thrown on the mercy of the Government or put in the clutches of the Government, however you want to look at it. Think of the blow to American individualism that this one element of the problem threatens!

— *The Providence Journal*, August 5, 1943

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Soldiers on the
HOME FRONT

No group of individuals is doing such a courageous and patriotic wartime job as are the American farmers. Despite shortages of help and unfavorable weather the farmers are doing everything possible to meet the increased food production goal set for 1943. And among this legion of unsung heroes are the dairy farmers of New England. In the face of serious feed shortages and the difficulties of securing competent farm labor they are today producing more milk than at any time in our history.

We at H. P. Hood & Sons, as distributors of quality milk, are in a position to see the job the farmer is doing and we are proud to be a member of the team that provides so many of thousands of New Englanders with America's number one food—fluid milk. There has been no reduction in the quality of this product and today as always it is the most important single food item which provides us with so many vitally necessary food constituents – calcium – protein – carbohydrates – fats – phosphorus – and vitamins.



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ESTIMATING THE DOCTOR'S INCOME TAX

JOHN A. O'CONNELL

The Author. *Chief, Income Tax Division, Providence Office, Collector of Internal Revenue*

Q. Does every doctor have to file an estimate of 1943 income taxes, or only the doctor on a salary basis?

A. Yes; the following persons are required to file a Declaration on or before Sept. 15th:

(a) Those not subject to the withholding tax whose gross income for the year can reasonably be expected to be such as to require the making of an income tax return (that is, those anticipating a gross income of $500 or more if single, or $1200 or more if married.)

(b) Those subject to the withholding tax, but whose wage or salary can reasonably be expected to exceed $2,700 if single, or $3,500 if married, or did exceed such amounts for the previous year.

(c) Those subject to the withholding tax, but whose income from sources other than wages or salaries can reasonably be expected to exceed $100 and whose gross income be such as to require the making of an income tax return, or did exceed $100 in the previous year and an income tax return was required to be filed, or would have been required if the marital status had been the same.

(d) Those required to make a return for 1942 whose gross income from wages or salaries in such year was greater than can reasonably be expected to be received from this source in 1943.

Q. What about the tax installments paid by the doctor last March and June?

A. The amounts paid on the 1942 liability are credited when the Declaration of Estimated Tax for 1943 is filed September 15.

Q. What about the Victory Tax as applied to the doctor?

A. The Victory Tax is imposed on individuals at the rate of 5 per cent on all Victory Tax net income in excess of $624 a year. Victory Tax net income is practically gross income, except for individuals engaged in trade or business; for although there are deductions allowed against gross income, they are allowed only to the extent connected with trade or business except that:

(1) The deduction for alimony is allowed.

(2) The deduction for unlimited contributions is allowed. (Code sec. 120)

(3) Estates and trusts are allowed all deductions which are allowed on the regular income tax return.

There is a post-war credit allowed of 40% of the Victory Tax in the case of married persons or a head of a family ($1,000 maximum for any one year) and 25% of the Victory Tax in the case of a single person ($500 maximum for any one year). There is also allowed for each dependent 2% of the Victory Tax, or $100 maximum for any one year. This credit may be taken immediately if the taxpayer has purchased defense bonds, paid life insurance premiums or reduced indebtedness in the amount of the credit.

Q. Suppose the total tax for 1943 is less than the amount due for 1942.

A. If the 1942 tax was greater than the 1943 tax, including the Victory Tax, the amount to be added to the 1943 tax is the sum of (1) the excess of the 1942 tax over the 1943 tax, and (2) if the tax for 1943 is more than $50, an amount equal to 25% of the 1943 tax, or the excess of the 1943 tax over $50 whichever is the lesser.

Q. What is the penalty for failing to file an estimate on time?

A. For failure to make the declaration and file it on time there is a penalty of 10% of the tax.

Q. Since the doctor's income varies in different quarters of the year how much leeway is allowed in estimating income?

A. A 6% interest penalty is imposed where the taxpayer substantially underestimates his tax, the purpose of which is to induce the making of reasonably accurate Declarations of Estimated Tax.

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WARTIME GRADUATE MEDICAL MEETINGS

ALEX M. BURGESS, M.D.

The Author, *Alex M. Burgess, M.D., Rhode Island and American College of Physicians Representative on New England Committee for Wartime Graduate Medical Meetings.*

THE New England Committee for Wartime Graduate Medical meetings represents the combined efforts of the state medical societies of New England and the national committee for Wartime Graduate Medical Meetings sponsored by the American Medical Association, the American College of Physicians and the American College of Surgeons. The New England committee consists of members of the original wartime graduate committee of the Massachusetts Medical Society, representatives from the other state medical societies in New England and the members of District 1 and 2 as appointed by the National Committee. Representatives of the First Service Command (Army), the First Naval District and the Coast Guard are also serving with this Committee.

Following discussion meetings at Boston and Providence the Committee has consolidated Region 2, consisting of Rhode Island and Connecticut, with Region 1 which comprises the remainder of New England. By this action plans and progress will be uniform throughout the First Service Command. The Committee has also approached the question of type of meeting and has decided, in view of the large military and naval installations in this region, to conduct a three day meeting in Newport, R. I., as the first assembly for the medical officers in the armed forces serving at home stations. This meeting is planned at the invitation of these medical officers.

The Newport meeting will be held on September 14-15-16 at the Naval Hospital. The program as now planned calls for a one day presentation of medical subjects, one day of surgical subjects, and a day program to include subjects in various fields of medicine. Some twenty-five speakers will present papers for discussion.

In addition to the medical personnel at the Naval Hospital, the medical officers at the Naval Training Station, the Naval Torpedo Station, the Naval Air Station at Quonset, the Navy Construction Battalion at Camp Endicott, the Navy Fuel Depot, and at the coast artillery forts stationed in the defenses of Narragansett Bay, will be invited to attend the wartime graduate meeting. The total medical officer personnel in these installations is approximately 160.

In October the Committee hopes to hold a two or three day program at New London for the benefit of the installation there which includes the Naval Hospital, the Submarine Base, and a large group of Public Health Service personnel attached to the Coast Guard Academy and the United States Maritime Service. By special arrangement the medical officer personnel of the Coast Artillery in the Long Island Sound defenses at Fort Wright, Fort Terry and Fort Michie will also attend, as these posts have been assigned to Region 2.

At some later date a program will be planned for the staff of the Station Hospital at Bradley Field.

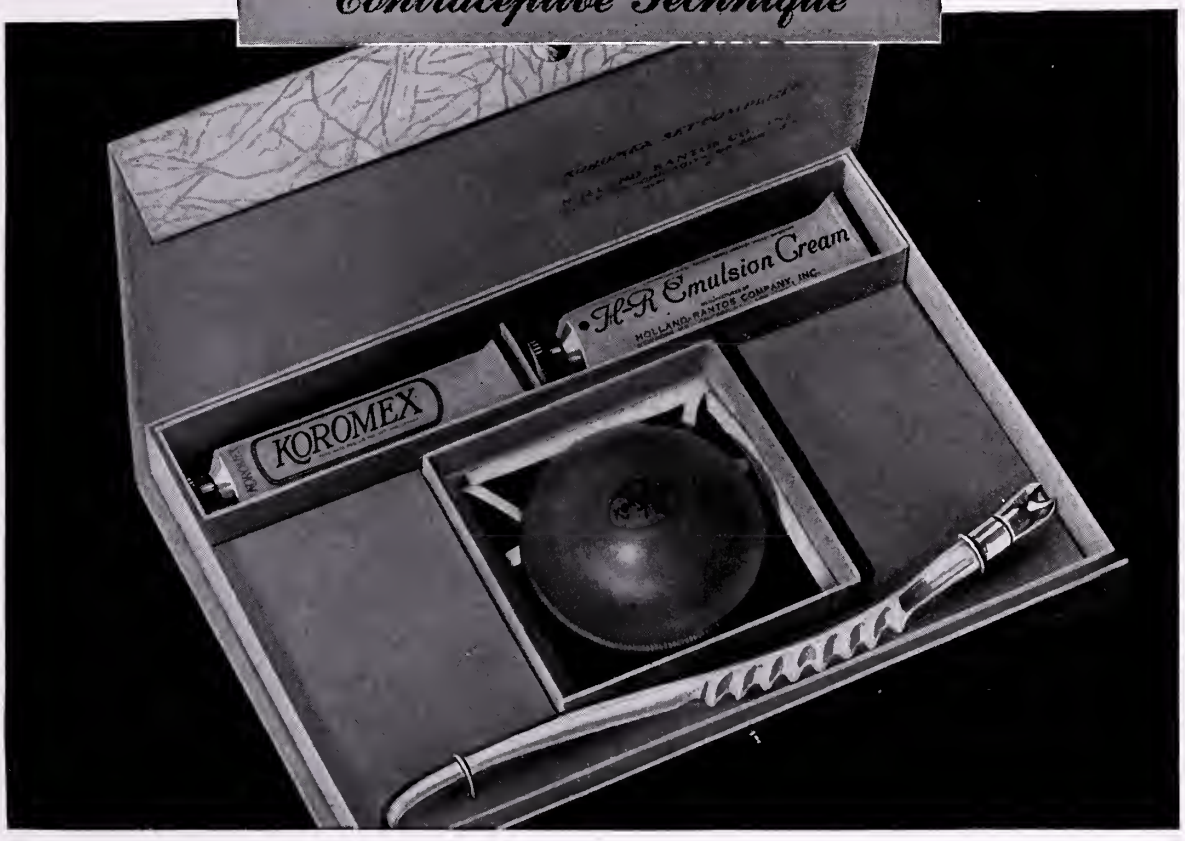
The committee arranging and directing the programs in the Rhode Island-Connecticut region consists of Creighton Barker, M.D., chairman, executive secretary of the Connecticut State Medical Society, Samuel C. Harvey, M.D., of New Haven, representing the American College of Surgeons, and Alex M. Burgess, M.D., of Providence, representing the American College of Physicians.

LUXURY OF SOCIAL INSURANCE

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Broad discussion and resulting compromise between conflicting views is a part of the process whereby a democracy can win freedom from want. The program involves a positive approach to the leaders of all component groups of our society, especially management, medicine, labor and agriculture, to the end that all recognize their stake in the decisions and so far as possible agree in going before the people with constructive principles to guide the general discussion and to lay a foundation for an atmosphere in which we can effectively rebuild a sound economy. If responsible, temperate and intelligent leaders of each component of society realize the stake which each has in free private enterprise and understand the relationship between the economy and social security, then all Americans can look with optimism towards the future.

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MEDICAL LIBRARY NOTES

COMMITTEE ON THE LIBRARY:
Herbert G. Partridge, M.D.; Samuel Adelson, M.D.; Adolph W. Eckstein, M.D.

Library Additions

THE Librarian of the Rhode Island Medical Society Library announces the recent addition of the following books:

Directory of Hospitals and Convalescent Institutions Engaged in Work for Crippled Children in the United States of America. Elyria, Ohio, 1942.

HEART

Thomas J. Dry—A Manual of Cardiology. Phil., 1943.

LIBRARY SCIENCE

Handbook of Medical Library Practice. Chic., 1943.

MALPRACTICE

Louis J. Regan—Medical Malpractice.

NUTRITION

James S. McLester — Nutrition and Diet in Health and Disease. 4th ed. Phil., 1943.

PHARMACOLOGY

New and Nonofficial Remedies, 1943. A. M. A. Chic., 1943.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1942. Chic., 1943.

SPECIAL GIFTS

The Committee on the Library reports with appreciation the receipt of the following gifts to the Library during the past month:

32 bound volumes and unbound journals from Butler Hospital.

23 volumes from N. Darrell Harvey, M. D.

1 volume from Miss Mary Daboll.

LIBRARY HOURS

On Tuesday, September 7, the Library resumes its regular schedule of hours. Until further notice the Library will be open from 9 a. m. to 5 p. m. on weekdays except Saturday, when it will be open from 9 a. m. to 12 noon.

Book Reviews

NUTRITION AND DIET IN HEALTH AND DISEASE, by JAMES S. MCLESTER, M.D., Professor of Medicine, University of Alabama. *Published by* W. B. Saunders Company, Philadelphia, 1943.

This, the fourth edition of "Nutrition and Diet in Health and Disease", has 850 pages and brings the science of nutrition with its recent and striking advances up to date. The investigations of the last decade, impressions gained from the military draft and war effort with more recent and intensified nutritional studies and particularly the work and recommendations of the Food and Nutrition Board of The National Research Council has helped to put this science in its rightful and highly important place in the field of medicine.

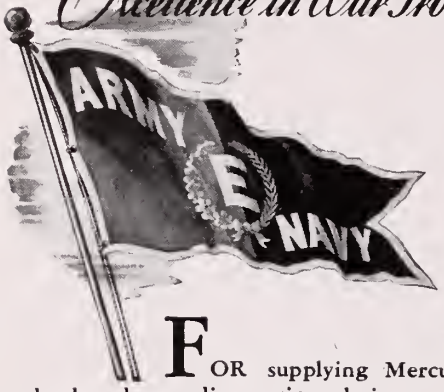
The author of "Nutrition and Diet in Health and Disease" is one well known to, and respected by, the medical profession. His many years interest in metabolic disease and the fact that he has served as president and chairman of the Council on Foods and Nutrition of A.M.A., served on the National Research Council, and other important nutritional committees, makes him ideally qualified to speak authoritatively on the subject of nutrition.

Dr. McLester has arranged his subjects conveniently into two parts and thirty chapters. Part I thoroughly discusses the physiology or mechanism of digestion, and metabolism with its requirements, then brings up to date vitamins, mineral salts and water, followed by several practical chapters with many tables on food products, the normal well balanced diet, infant feeding and diets in pregnancy etc.

Part II is given over to nutrition in disease. This is divided into separate chapters as follows: deficiency diseases, diabetes, gout, obesity, and leanness, food poisoning and allergy, diseases related to the urinary tract, digestive tract, blood circulatory system, nervous system, joints, skin, and endocrine glands as well as chapters on febrile diseases, the feeding of the surgical patient and nutrition in industry.

continued on page 182

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NEWS FROM THE WAR FRONT

INDIAN ODYSSEY

(The following account of travel by train by one of our doctors in India was dispatched to a member recently)

June 1, 1943

"Dear Doctor —

Back where I started from after two weeks of travel on Indian railroads and river boats. Quite different from the railroad in the United States. None of the comforts. Cars are very dirty. No drinking water; frequently none for washing. Travel very slowly and stop every four or five miles, so that you rarely travel more than 150 miles in twenty-four hours. Carry your own bedding to sleep on wood benches, which are leather upholstered and loaded with vermin. No facilities for checking baggage. Handle your own. I had all my belongings, trunks, tentage, bedding roll, suitcase, laundry bag with shoes, etc. There is a baggage car into which you can put baggage yourself or hire coolies to deposit it. Not checked or guarded. At next station if someone likes the looks of your suitcase he can easily pick it up and carry it out—no questions asked. Windows and doors must be securely barred at night. Once we forgot to lock one of the doors of one compartment and we woke at three o'clock in the morning to find a coolie wandering about inside. Coaches are continental style with doors on each compartment opening outside. No passageway from compartment to compartment.

The greatest inconvenience is the frequent changes. Each line runs a different gauge. The gauges run from a metre up to six feet. Sometimes you change twice a day and often have to cross rivers on ferries. Each change means lugging all your baggage across. No food available. Have to carry your own, or pick up odds and ends at some towns.

The best part of traveling around this way is that you do see the country and the people firsthand, both civil and military. I now realize how little of the newspaper propaganda you can accept as fact. Particularly the readable dramatized reports I used to read in ——— magazine. As you used to say about hysteria, all the conflicting reports and opinions are based on just an oasis of truth, and lots of imagination."

NEWS FROM 'DOWN UNDER'

Australia is a long way from these Plantations and as a result we are pleased when we get news from Captain Morgan Cutts who is rounding out a year of service in the South Pacific. There is "very little exciting to report," according to Dr. Cutts, but we are strongly of the opinion that there has been much work done. Apparently the threat of malaria in a postwar world will be thwarted by the first hand experience our doctors are getting in the treatment of cases in tropical areas. The disease is the big problem in the Pacific war, and as Dr. Cutts reports it is getting so "that now anyone from the north is considered guilty of having malaria until proven innocent."

ADVENTURE IN BURMA

Captain William L. Leet, MC, historian of the 48th Unit, will have plenty to report when he sits down to his task of recording the work and travels of the Rhode Island Unit. Our latest report from Dr. Leet had him off on a jungle adventure which took him a thousand miles ahead of the Unit on a medical research mission into Burma. He reports "the rainfall here is terrific—as many inches a day as there are towers at the R. I. hospital . . . but we've managed to keep our health pretty well for the most part."

MILITARY ROUNDUP

Home for a brief furlough after long service in Alaska, Major Joseph C. Kent has departed for the warmer climate of Georgia where he takes over an assignment at the station hospital at Fort Benning. . . . It is Lt. Comdr. Edward H. McCaughey now, as the former Pawtucket Medical Association president has been commissioned and assigned to the Newport Naval Station. . . . Good news to report

continued on page 180

AN important new industry began operation in Rhode Island when Owens-Corning Fiberglas Corporation opened its Ashton plant in June 1941.

Since then, personnel has been increased 2400 per cent to produce and meet steadily increasing demands for Fiberglas textiles now allocated for vital war applications.

Fiberglas expects to be a permanent part of Rhode Island industry, because glass fibers have tremendous potentials in peacetime markets. Many new uses of Fiberglas will be added to those of the prewar period, too many to list here.

So, as a member of the Rhode Island Medical Society, we believe you will be interested in the annotated bibliography on the possibility of occupational hazards arising from the manufacture and handling of Fiberglas materials.

For your convenience, available data are listed on this page.

OWENS-CORNING FIBERGLAS CORPORATION · TOLEDO, OHIO

FACTORIES: ASHTON, R. I., HUNTINGDON, PA., NEWARK, OHIO

ANNOTATED BIBLIOGRAPHY

LUNGS AND RESPIRATORY TRACT

Gardner, Leroy U., M.D., "Report of the Director of The Trudeau Foundation—1941" in *The Fifty Seventh Annual Medical Report of the Trudeau Sanatorium and the Thirty Seventh Medical Supplement for the Year ending September 30, 1941, together with the Twenty-Fifth Collection of the Studies of the Edward L. Trudeau Foundation for Research and Teaching in Tuberculosis.*

On the last page, Dr. Gardner reports that work carried on at the Saranac Laboratories in 1941 has demonstrated that exposure to dust of glass wool involves no hazard for the lungs because this fibrous material is not inhalable.

"Fibrous Glass Insulation Not Harmful" in *The Philadelphia Navy Yard Beacon*, Vol. II, No. 15, (February 5, 1943), p. 2.

This article reports conclusions based on an investigation by the Bureau of Ships and the Bureau of Medicine and Surgery of the Navy Department. Final statement: "It is concluded from observations, investigations and available literature that there is no appreciable health hazard associated with the handling of fibrous glass and slag wool in the blanket or board form."

Entitled "Fibrous Glass Insulation: Health Aspects of," a report of the investigation is contained in a memorandum dated December 30, 1942 which is indexed as BUSHIPS S38.1 (3638) FN28/A2 11 and BUMED FS/S38.1 (101).

SKIN

Sulzberger, Marion B., M.D., and Baer, Rudolf L., M.D., with the technical assistance of Lowenberg, Clare, M.S., and Monzel, Hildegard, B.S., "The Effects of Fiberglas on Animal and Human Skin—Experimental Investigation" in *Industrial Medicine*, Vol. XI, No. 10 (October, 1942), pp. 482-484.

Report of clinical investigation of effects of glass fibers on the skin, in which the authors find: "All of the reactions observed were of a transitory and superficial nature."

Schwartz, Louis, Medical Director, and Botvinick, Isadore, P.A. Surgeon, Division of Industrial Hygiene, National Institute of Health, United States Public Health Service, "Skin Hazards in the Manufacture of Glass Wool and Thread" in *Industrial Medicine*, Vol. XII, No. 3 (March, 1943), pp. 142-144.

GENERAL HEALTH

Siebert, Walter J., M.D., "Fiberglas Health Hazard Investigation" in *Industrial Medicine*, Vol. XI, No. 1 (January, 1942), pp. 6-9.

Report on investigation to determine whether manufacture or handling of Fiberglas involves any unusual occupational hazards.

"Ilgenator With Dust-Stop Filter Acceptable" in *Journal of the American Medical Association*, Vol. CXVII, No. 11 (September 13, 1941), p. 932.

Description of unit placed in window frame equipped with Fiberglas air filter to remove pollen from air entering room. Offers relief to hay fever victims.

W. G. Hazard, P.A. Industrial Hygiene Engineer (R), U.S.P.H.S., "Transcript of Remarks on Health Aspects of Fiberglas Materials." Excerpt from the Proceedings of the Rhode Island Industrial Health Institute, May 19, 1941, 4 pages. Copies available on request to Division of Industrial Hygiene, R.I. Dept. of Health, Providence.

The transcript concludes:

"The job of the industrial hygienist is to show manufacturers how they can use all manner of materials safely, without injury to any worker. In the case of Fiberglas, the danger is not real but imaginary. The following points might well be discussed with employees when they are hired, and periodically afterwards:

1. Breathing glass fiber dust is not harmful to the lungs.
2. Irritation of the skin is temporary, superficial, and not progressive.
3. No special personal protective devices or clothing need be worn, except that an overhead application of glass fiber, goggles are often desirable to protect against falling bodies.
4. Frequent washing and a daily shower with soap and warm water will readily remove most of the small fibers clinging to the skin and will relieve any "itching."

FIBERGLAS IN SURGERY

Lewison, Edward F., Captain, Medical Corps, United States Army, "Bayable Gauze As a Factor of Safety in Surgical Operations" in *Bulletin of the American College of Surgeons*, Vol. XXVII, No. 1 (January, 1942), pp. 39-40.

Report on use of a strand of Fiberglas yarn as a tracer thread in surgical sponges. Writes Dr. Lewison: "Like glass, which is the basic constituent of its composition, this [Fiberglas] thread is chemically, physically, and biologically inert, yet unlike glass it is a thread of exceptional strength, soft texture, and remarkable plasticity . . . It was, therefore, almost inevitable that the hidden aptitudes of a specially prepared radio-opaque fiberglas yarn should be discerned and a thread developed which was permanently impenetrable to the X-ray and perfectly harmless to body tissue as well."

Scholz, Roy Philip, M.D., and Mountjoy, Philip S., M. D. "Fiberglas Suture Material" in *American Journal of Surgery*, Vol. LVI, No. 3 (June, 1942), pp. 619-21.

Report on experimental use of Fiberglas sutures in animal and human surgery. Dr. Scholz and Dr. Mountjoy write: ". . . Because Fiberglas is inert and non-reacting in the tissue, and practically insoluble, it does not cause exudation, edema, or cell proliferation; and it in no wise interferes with wound healing . . . It is not affected by tissue fluids, enzemotic action, or action of chemicals; neither does it produce toxins or allergic reaction. The fact that each fiber is an extremely fine, solid filament of pure glass, makes it non-absorbent, and in view of its being a non-irritant, it does not call forth tissue fluids which would harbor germ life."

"New Type Plasma Filter Will Aid in Prevention of Fatal Wound Shock" in *Surgical Business*, Vol. V, No. 5 (May, 1942), pp. 20-21.

Fiberglas tape used as filter in blood plasma transfusion apparatus.

HANDLING CHARACTERISTICS

Rogers, Tyler Stewart, "Safe Practice in the Manufacture and Uses of Fiberglas," issued as *Safe Practice Bulletin No. 58* (February, 1940), in the Occupational Disease Prevention Series published at Harrisburg by the Pennsylvania Department of Labor and Industry.

Mr. Rogers reports: "Fiberglas is cleaner, holds together better, contains less 'dust' and foreign materials than the common rock wool and slag wool insulations used for over fifty years . . . Fiberglas employees have compiled an outstanding health record covering millions of man hours of handling Fiberglas products."

McIlvain, E. H., M.D., "Insulation in Streamlined Trains," issued as *Safe Practice Bulletin No. 2* (1939) in the Occupational Disease Prevention Series published at Harrisburg by the Pennsylvania Department of Labor and Industry.

Dr. McIlvain reports: "Fiberglas provides the qualities generally sought as an insulation product in streamlined trains and in addition has proven safe for handling purposes by our workmen."

Keiser, Hubert D., Major, A. U. S., "Use of Fibrous Glass by the Army and Navy," in *Mining Technology*, Volume VII, No. 3 (May, 1943), Technical Publication No. 1598 (Class H, Industrial Minerals Division, No. 107), pp. 1-14.

This is a reprint of an address delivered by Major Keiser in New York City on February 15, 1943, before a joint session of the American Society of Economic Geologists and the Industrial Materials Division of the American Institute of Mining and Metallurgical Engineers. The article contains a comprehensive description of manufacturing processes,

INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., Chairman; Herbert E. Harris, M.D.; Stanley D. Davies, M.D.; Michael H. Sullivan, M.D.; William P. Buffum, M.D.

In these days of rationing of food, fuel and even manpower, the physician is often called upon to supply statements regarding the need for additional gasoline, fuel oil or red ration points. He is also occasionally required to certify that a patient's welfare will be improved by changing jobs. Before issuing or signing such statements it is the duty of the physician, as a citizen having civic responsibility of his own, to satisfy himself that a definite need exists and that the situation seriously warrants his professional intervention. The physician who acquiesces to such a request merely to please the patient is seriously undermining the war effort. It should be realized by all that a great deal of time and effort have gone into the planning of our war economy. While it is admittedly not perfect it is designed to insure the welfare of the general mass of people.

The Committee on Industrial Health is particularly concerned with the situation regarding shifting jobs in industry. When an employee desires to change his occupation there are six conditions which may be applied to determine his eligibility for a Certificate Of Availability. They are as follows:

1. The worker is competent to perform higher skilled work than the present employer is able or willing to provide.
2. The worker is employed for a substantial period at less than full time.
3. The place of prospective employment is substantially less remote and the distance between the worker's residence and the present place of employment is unreasonably great, or customary transportation and facilities are not available.
4. The present employment is detrimental to the health, safety, or morale of the worker or his immmediate dependents.
5. The worker is discharged by his last employer.
6. The worker is laid off for an indefinite period or for a period of seven or more days.

The State Unemployment Commission carefully and thoroughly investigates the circumstances of each case and if the evidence presented warrants a change of employment it is granted.

Of late, however, the effort to be fair to all applicants has been jeopardized by the fact that an increasing number of employees are presenting a slip from the doctor stating that a change of occupation is needed. Up to now that has been taken at its face value but investigation shows in many instances that there is no improvement of working conditions at the prospective place of employment over the present employment. The doctor's certificate was merely used as a lever to force a Certificate Of Availability for which the applicant was otherwise ineligible.

We can sympathize with workers who desire to leave essential war jobs for personal aggrandizement but the medical profession must not be used as a tool to sabotage essential war industry. Ample safeguards have been established to insure justice to all workers and they do not need to rely on provision number four unless their physical condition is such that a definite clinical entity exists.

The Committee on Industrial Health has cooperated in devising a form to cover cases applying under provision number four, and all physicians are advised to give a thorough appraisal of the applicant's condition and decide in what manner the change in occupation will be beneficial. We realize that this means additional paper work and effort on the part of an already overburdened physician, but because in the past physicians have given their approval to changes on wholly inadequate evidence, it is necessary to revise the system. In doubtful cases it is suggested the physician gently but firmly remind the patient that obligations rest heavily on the physician's shoulders and that his certificates are subject to further review; therefore they must rest on solid facts. All certificates from physicians, whether for change of occupation, for additional red ration points, or for additional fuel oil coupons, will continue to receive respect from authorities only when given under proper auspices.

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FROM THE SECRETARY'S DESK

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SPECIAL CONFERENCE HELD

On August 18, at the invitation of Dr. Michael H. Sullivan, president of the Society, the Council met with the president and the secretary of each of the component district societies, and with the chairman of the state Procurement and Assignment committee. Called together to confer on the relationship of the State and the district societies, especially in regard to memberships, and also on the problems arising from a possible shortage of physicians during the coming months, the Conference evoked much thoughtful discussion. Recommendations stemming from the meeting will undoubtedly be considered further by the Council, and will be submitted to the House of Delegates at the September meeting.

THE OPA AND THE MEDICAL PROFESSION

Recognizing the need for full cooperation by the medical profession, The Council agreed to view the case of any doctor who flagrantly violated the gasoline restrictions. From state OPA director, Christopher DelSesto, has come word of appreciation for this evidence of cooperation, and the further comment that "we realize the tremendous strain under which the members of the medical profession are now working and it should be our earnest hope in the Office of Price Administration that we can do whatever possible to ease the load of the medical profession. The complaints that we have received at this office concerning the members of the medical profession violating OPA regulations have been few."

Every doctor is strongly urged to continue this excellent cooperation.

MASSACHUSETTS PRE-MARITAL LAW

The attention of members is called to the new pre-marital blood test law which has been enacted in Massachusetts. Essentially the same as the old law, the new act includes the following changes: (1) the examination shall be made only to ascertain the presence or absence of syphilis, and shall include a serological test for syphilis; (2) the health certificate need not be presented until the time of issuance of the marriage license, and the examination and laboratory test must be made not more than 30 days before the date the marriage license is issued; (3) the examination may be made by a physician registered or licensed to practice in any other State.

LEGAL MEDICINE CONFERENCE AND SEMINARY

The Massachusetts Medico-Legal Society in conjunction with the department of legal medicine of Harvard Medical School will hold an all day conference at the Mallory Institute, Boston City Hospital, on October 6. Rhode Island doctors interested are invited to attend the lectures, demonstrations and informal discussions to be held. During the week October 4-9 the Harvard Medical School will offer a Seminar in Legal Medicine open to medical examiners and any other suitable graduate of an approved medical school.

TAX FORMS

Income tax forms will be available to members at the executive office.

MEETINGS IN SEPTEMBER

Thurs. SEPT. 9—Kent County Medical Society. Regular meeting.

Wed. SEPT. 15—Council of R. I. Medical Society. At Hope Club, 7 p.m.

Thurs. SEPT. 16—Pawtucket Medical Ass'n. Regular meeting at 12 noon.

Thurs. SEPT. 23—House of Delegates of R. I. Medical Society. At the Medical Library, 8:30 p.m.

Thurs. SEPT. 23-*Sat.* SEPT. 25—R. I. Conference of Social Work. Annual meeting. At Providence.

Tues. SEPT. 28—Newport County Medical Society. Regular meeting.

Mon. OCT. 4—Providence Medical Ass'n. Regular meeting. At the Medical Library, 8:30 p.m.

The School Child

With schools now in full swing, the maintenance of nutritional balance in children of this age group is an important factor. During war-time the problem of keeping children well and fit looms larger than ever in the practice of medicine.

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MEDICAL ASPECTS OF CASH SICKNESS ACT

HUGH J. HALL, M.D.

The Author. *Medical Examiner, Rhode Island Cash Sickness Act.*

ANY DISCUSSION of the medical aspects of the Rhode Island Cash Sickness Act which has been paying benefits to claimants since April 1 must necessarily be prefaced with the information that the Act is a law of the state which requires cooperation of the medical profession for its successful operation. Basically this is a financial program whereby the loss of wages from employment due to illness is offset in part by cash payments from a fund created by payroll deductions from workers under the Cash Sickness Compensation Act. The law is nevertheless almost wholly dependent upon the medical certification of the private practitioner for its operation. For this reason every doctor must realize that he has an obligation to cooperate in the development of the program.

Thousands of claims have been viewed by the medical examiner and every effort has been made to give the claimants all the possible benefits due them as the result of the diagnosis reported by the private physician. The administering Board has been conscious of the many demands upon the time of the doctors of the State and has endeavored to simplify the medical certification report forms. In the beginning many reports of diagnosis were incomplete and the forms had to be returned to the doctor for further information. Thus, because of experience acquired we have revised the claim forms and we have made the reporting less tedious for all parties concerned.

Disability Must Totally Incapacitate

By regulation of the Unemployment Compensation Board provision has been made for the medical examination of all applicants, including those filing initial claims and for those receiving benefits when the time allowance for disability granted by the medical director has expired and continued benefits are sought. The Board is of the opinion that it is fair to the claimant as well as to the State for these people to be examined by the medical staff before any benefit or extension of benefit, as the case may be, is granted. There is no desire to avoid just claims, but after seeing the patient and personally examining him the medical staff is in a better position to judge the disability. When special conditions arise claimants are sent to a specialist in the particular field.

In this connection it should be carefully noted by every doctor that the wording of the Sickness Act stipulates that "an individual shall be deemed sick in any week in which, because of his physical or mental condition, he is unable to perform *any services* for wages." This actually means total incapacity, and it should be brought to the attention of patients who seek the doctor's signature to a certificate of illness. The doctor should have no hesitation in refusing to sign forms for patients in whom he detects no disability which would be serious enough to prevent any work whatever.

Basis for Judging Claims

In judging claims for benefits the following factors are considered: (1) a complete diagnosis, (2) the age of the patient, (3) the type of work pursued by patient, (4) the first day of sickness, (5) the last day worked, (6) special attention to surgical cases.

In surgical cases a definite number of weeks are allowed provided there are no complications. The present schedule is as follows: Appendectomy—6 weeks; hernia — 6-8 weeks; gall bladder — 6-8 weeks; hysterectomy—6-8 weeks; vaginal repair —8 weeks; thyroidectomy adenoma—4 weeks; thyroidectomy toxic — 6 weeks; hemorrhoid—4 weeks. In all such cases the age of the claimant and his type of work are vitally important and are given careful consideration.

Reports of sacro-iliac strains have been very numerous, especially with workers in heavy industries. Many such claimants, as the result of amendments to the Sickness Act this year, are able to receive workmen's compensation benefits along with the cash sickness payments and it has been the experience of the medical staff in examining such persons that there is a tendency on the part of the majority to prolong their illness. Our policy has been to allow a definite period for this condition and

after this time the claimant is called in and given a physical examination and if he is found to be able to work the claim for further benefits is denied.

Special Problems

There are several special problems I should like to call to the attention of the doctors. One concerns the situation where the doctor does not wish the patient to know the diagnosis for fear of upsetting him mentally. In such instances kindly inform the medical director by personal letter giving the patient's *social security number* and further benefit payments will be allowed and the patient will not have to come in for an examination.

Again, many of the claimants coming in for examination after the period of disability has expired show a different ailment from that originally described by the private physician. Hence it is important that every doctor be careful to note on the weekly report form if any change has occurred in the type of ailment subsequent to the initial report. The medical staff of the Compensation Board has to judge the claims on the basis of the private doctor's diagnosis and if other symptoms are present at the time of a review examination by the staff it is necessary to request the claimant to file a new form.

Finally, there has been an increasing number of reports of a "run down condition" due to overwork, and it is only by examination that we discover a blood pressure running from 190-240 which is not always reported by the private doctor. We ask that such information be added to the diagnosis in these cases. Likewise, if the doctor would send in the blood count and hemoglobin in cases of anemia the examining board will be in a better position to evaluate the claim and make the full allowance of benefits.

The medical staff of the board consisting of the director, and Drs. Henry Triedman and Raymond Luft, is aware of the many and varied problems facing the medical profession of the State and the Unemployment Compensation Board for the successful operation of the cash sickness act. In asking the complete cooperation of the doctors we assure them of our desire to be of service in every instance, and we will welcome assistance and communications relative to claims for benefits under the act that the entire program may prove as beneficial as possible to the citizens of Rhode Island.

NEWS FROM WAR FRONTS

continued from page 173

is the Navy announcement that Ensign Phillip H. Sanborn, son of Dr. and Mrs. Harvey B. Sanborn of Rumford, missing since the fall of Corregidor, is alive, though a prisoner of the Japanese. . . . After several cross country assignments Captain Alfred Mellucci has been located at San Diego with the medical department of the Aviation Cadet Examining Board. . . . From the Pacific area comes a brief message from Major Wallace Pianka who states he "has been thankful to some one for a foxhole more than once." . . . Latest recruit, according to our records, to answer the call for military duty is Dr. Maurice N. Kay, who reported to the 4th Service Command at Atlanta on August 24. . . . If the postwar world is to be featured by aerial service then Lt. Comdr. H. Frederic Stephens will have a wide edge on his colleagues, for he wears the Navy wings, having gone through the flight school at Pensacola. . . . Captain John Dziob and Lieut. Hubert Holdsworth, both with the 48th in India, now have extra special reasons to get back to these Plantations in a hurry—both have acquired heirs within the past month!

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BOOK REVIEWS

continued from page 171

Completing the book is a 60 page appendix taking up relative values and technic of special methods of feeding, the processing and storing of foods, methods of cooking and finally complete tables on the composition of foods and beverages with fuel, calorie, vitamin, and mineral values.

The importance of a thorough understanding of nutrition in Health and Disease is impressed upon us when we pause to consider that throughout the world today the incidence of nutritional diseases and all that follows, is multiplying into staggering figures due to the war. Our medical problems are becoming more and more closely linked up with nutritional problems.

This book then would seem very timely and should prove of great value to the entire medical profession, to the student of the biological sciences, to the dietitian, and also become an excellent book for nurses.

ELIHU S. WING, M.D.

REHABILITATION OF THE WAR INJURED — A Symposium. *Edited by* WILLIAM BROWN DOHERTY, M.D. and DAGOBERT D. RUNES, PH.D. Philosophical Library, New York, 1943.

This admirable volume is a compilation of reprints from United States and British medical journals, together with one from a Russian source. The book is divided into the following subjects: Neurology and Psychiatry, Reconstructive and Plastic Surgery, Orthopedics, Physiotherapy, Occupational Therapy and Vocational Guidance, and the Legal Aspects of Rehabilitation. A final chapter deals with the Vascular and Neurologic Lesions in Survivors of Shipwreck.

The authors are authorities in the special fields which are described, and the editors have made a wise and judicious selection both as to material and writers. Rehabilitation covers a wide range of medical practice, as witness articles on "Refinements in Reconstructive Surgery of the Face" and "Employment of Epileptics".

The paper and type are of excellent quality but the value of the book is greatly impaired by the inferior quality of the illustrations. Half-tone reproductions of photographs in many instances are so indistinct as to be of little service in evaluating the results of treatment. This blemish is conspicuous in such a subject as facial reconstruction, where a clear cut reproduction of the original is essential.

In spite of these faults the book will prove of great value to all practitioners who will take part in the greatest rehabilitation of war injured in history, — and that means a sizable proportion of the medical profession.

ROLAND HAMMOND, M.D.

ESTIMATING INCOME TAX

continued from page 167

However, a 20% tolerance is allowed, which means that the interest penalty does not apply unless the amounts paid during the year were less than 80% of the amount finally shown to be due. The interest is imposed on the total amount of the underpayment, not just the amount below 80%. As a practical matter, the penalty can be avoided in most cases by the filing of a revised declaration December 15, when the income and deductions for the year can be estimated with substantial accuracy, and by adjusting the final quarterly installment to take account of the change made.

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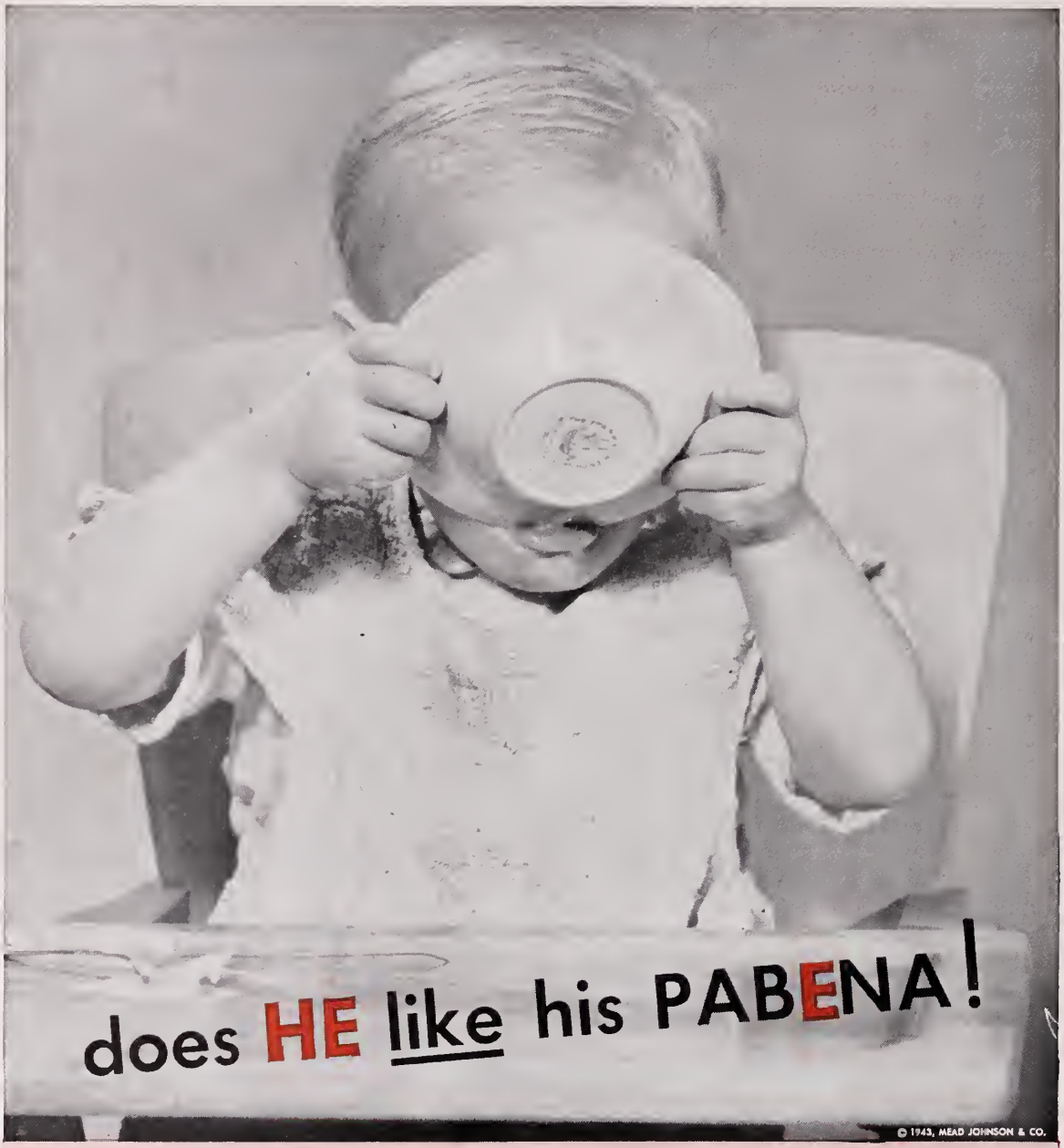


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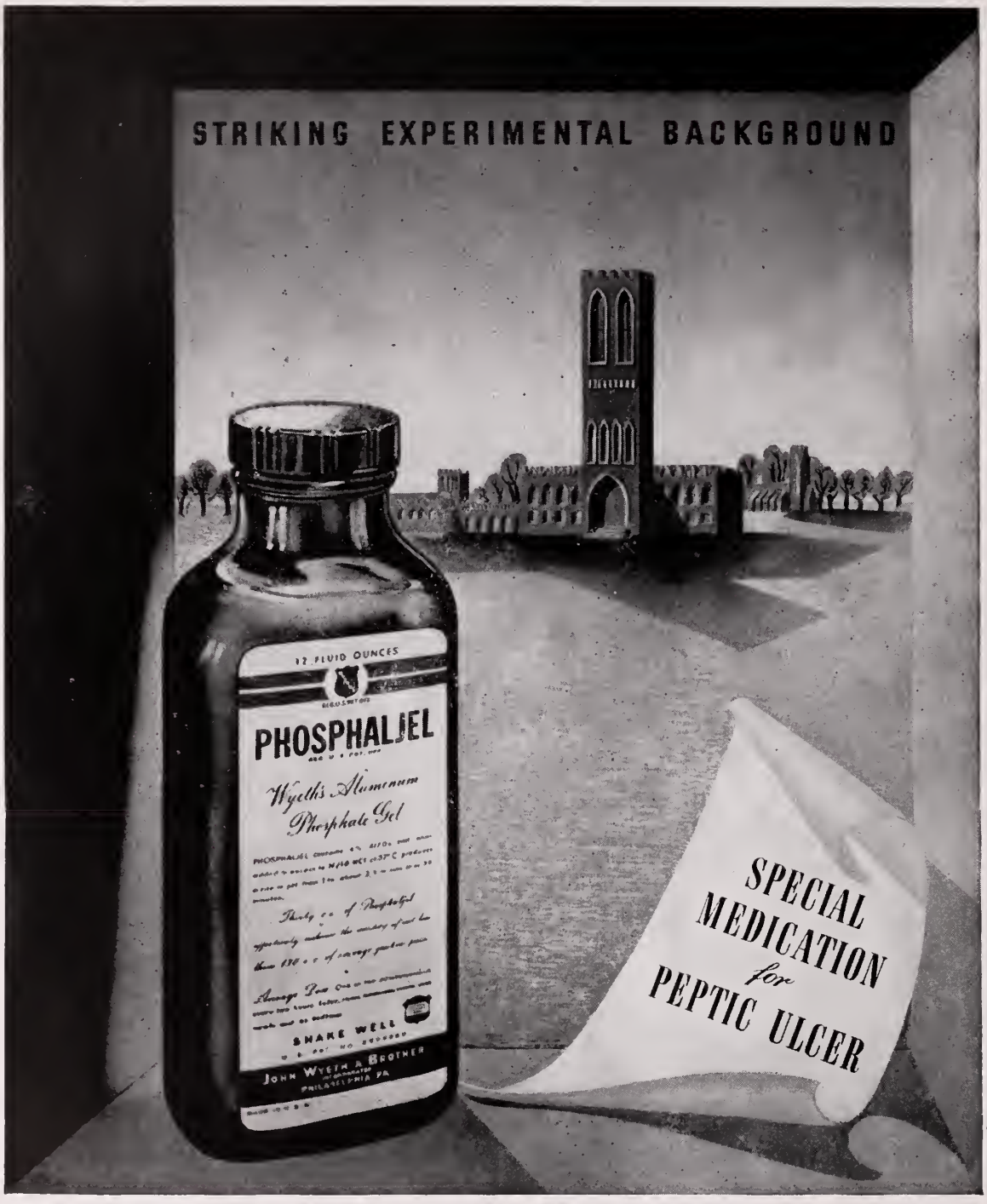
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First publication of an outstanding report on the treatment of "BURNS", by Charles C. Lund, M.D., of Boston by permission of the Committee on Medical Research of the Office of Scientific Research and Development *Page 197*

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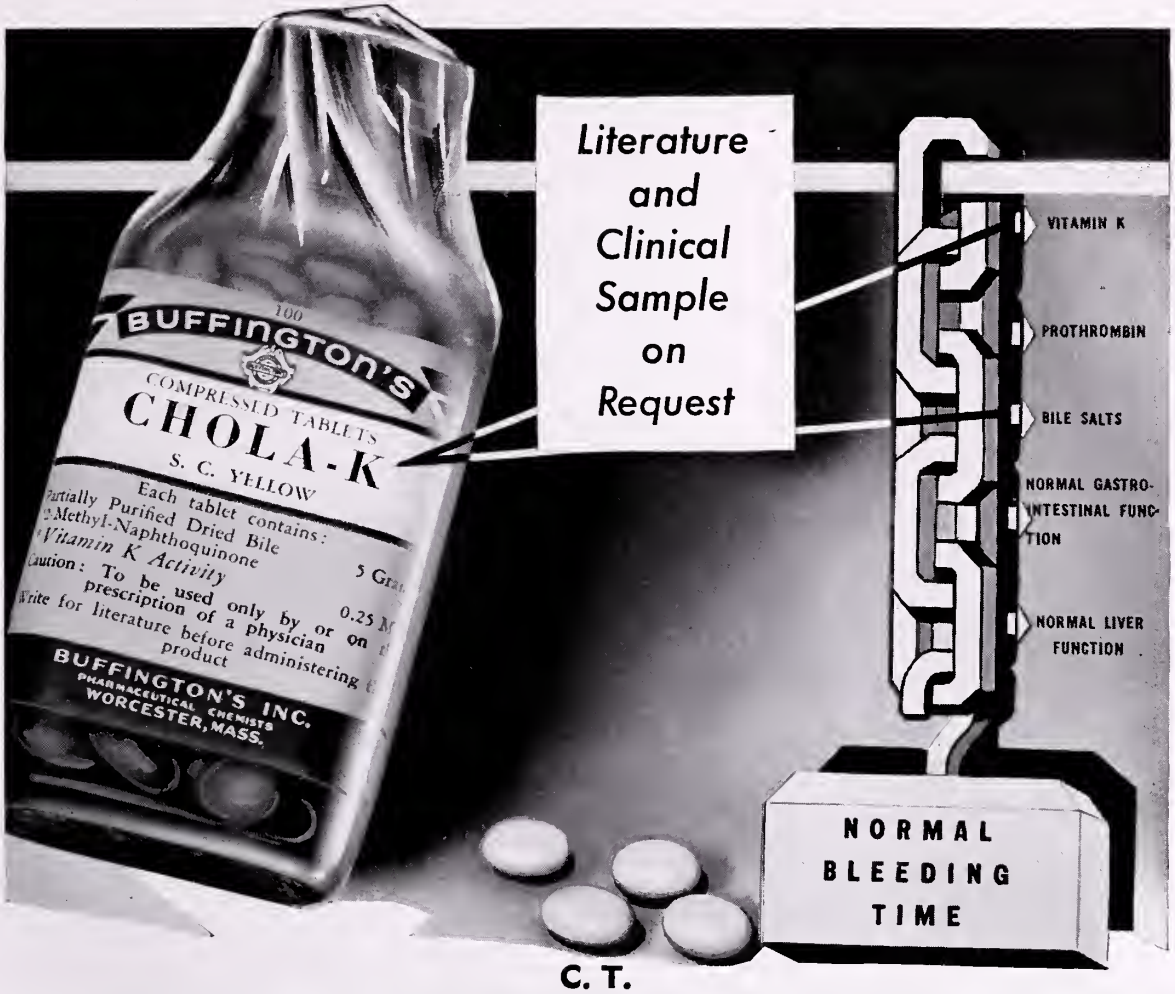
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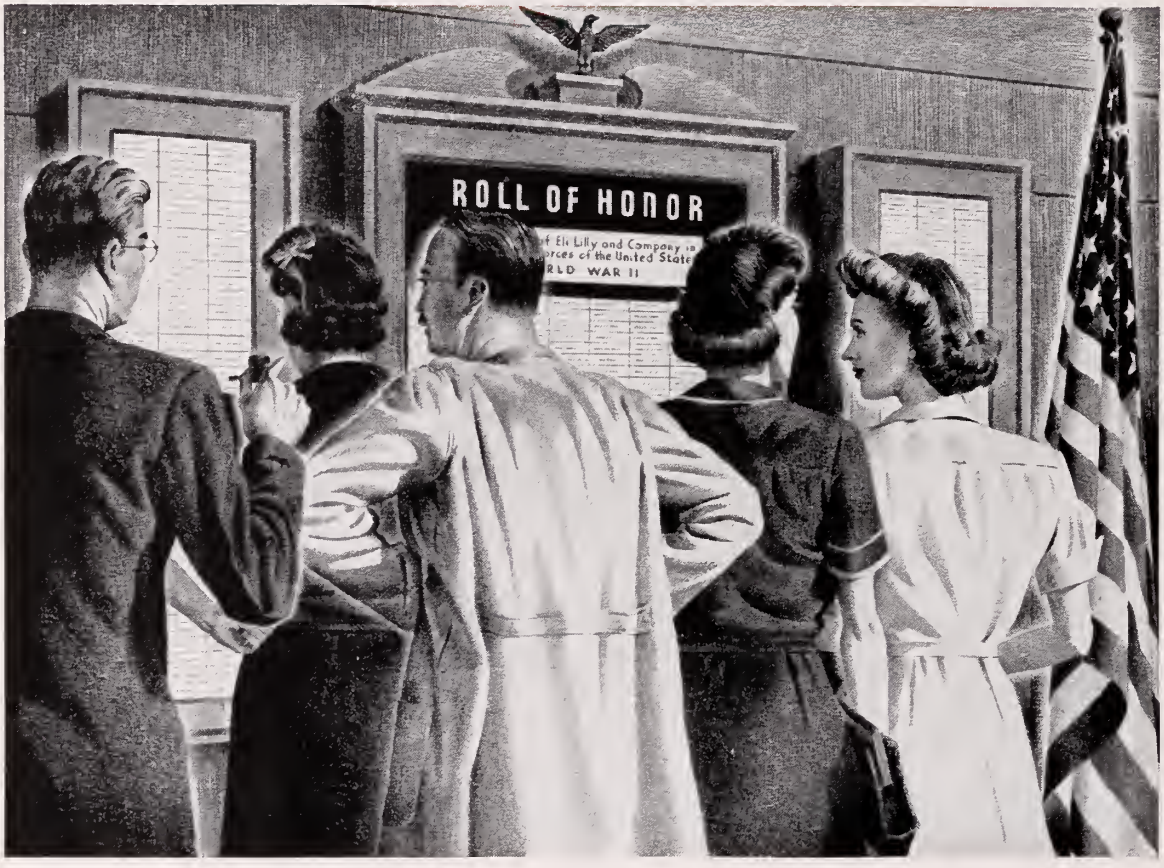
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVI OCTOBER, 1943 NO. 10

BURNS*

CHARLES C. LUND, M.D.

The Author. *Assistant Professor of Surgery, Harvard Medical School; Surgeon, Boston City Hospital*

First Aid

For about ten years most doctors have been preaching that ointments must never be used as a first aid treatment of burns but that tannic acid solution, either pure or improvised in the form of tea should be applied at once. If these were not available, saline or soda solutions were to be used. The reason for avoiding ointments was that they had to be removed before any escharotic treatment could be used. Now the British Army in the Middle East has forbidden the use of tannic acid[1] either as first aid or as definitive treatment and more and more individuals [2 3 4 5] and organizations [6] are advising simple ointments for first aid and for definite treatment. What has led to this extraordinary change of thought?

The escharotic treatments were introduced in the first place to reduce the degree of shock[7 8 9] and the severity of infections.[8 9] Shock was lessened by reduced surface weeping and infection influenced by antibacterial activity of some of the components of the eschar. Since the advent of plasma to replace that lost from the blood stream, and the use of pressure dressings[10] and plaster casts[11] in the surface treatment, the former purpose of the escharotics has become less important, and more critical evaluation of cases has shown that the latter purpose is not achieved in severe cases[3 12] and particularly if infection is locked in by tanning an uncleaned burn wound as occurs frequently under first aid conditions. In addition, some of the escharotics (tannic acid and triple dye)[13 14 15 3] delay the healing of small wounds and burns and some of them may poison some patients with large burns, (tannic acid[16 17] and picric acid.)[18] For these reasons the best recommendation for first aid that can be now made is some simple bland ointment such as plain petrolatum or boric acid ointment. If these are not available apply a dressing of saline or weak sodium bicarbonate solution and keep it moist.

Definitive Treatment of Minor Burns

For the purposes of this discussion, minor burns are defined as burns of small area (not over 5% of surface area) and of only part of the thickness of the skin. McClure[5] has recently pointed out the chaotic conditions prevailing in the treatment of minor burns in the various clinics of certain large industrial concerns. He urges the use of simple boric acid ointment well and firmly bandaged and infrequently changed. This is good advice because there are four major requirements for the successful treatment of such burns and this program meets all four of them. These requirements are prevention of pain, prevention of infection, optimum conditions for rapid healing, and minimum disability during and after treatment.

Pain is absent under either a pressure dressing such as is recommended by Allen and Koch[4] or under a plaster cast as recommended by Levenson and Lund.[11] To do a pressure dressing properly takes a little planning and a surprising amount of practice. However, once a suitable dressing has been applied it should not be removed from a part thickness burn until the burn is healed. As pain in a burn is caused only by friction or by changing the dressing, it is seen that following this program will eliminate practically all of it.

Infection can get into a burn only when the burn is uncovered or inadequately covered. Cope[3] has shown that even in major burns the contamination present at the time of arrival at a hospital is not a

*From the Burn Assignment of the Surgical Services of the Boston City Hospital and the Department of Surgery, Harvard Medical School, Boston, Mass.

The investigations reported in this article were made under a contract between the Committee on Medical Research of the Office of Scientific Research and Development and Harvard University.

particularly serious matter in most cases and that burns treated with sterile Boric Acid ointment with no attempt to wash the surface do as well as burns that are washed. The dangers in washing a burn are that the washing must be either inadequate or, when adequate, may be harmfully traumatizing to the tissues. Levenson and Lund,[11] Logie,[1] and Trueta,[19] have also shown that burns encased in plaster will take care of the infection that is on the surface, while Willits and Hare[20] show the ease and frequency with which burns and wounds become infected at changes of dressings. For these reasons a treatment to be safe from the standpoint of infection must be one in which dressings are not changed until healing has occurred.

Optimum conditions for healing are not created by escharotics, by antiseptics, by "shot gun" ointments or by nutritive ointments. Cells can only grow under certain conditions of moisture, temperature, pH, concentration of salts, etc., comparable to those prevailing in tissue fluid. These can only be created on the surface of the body by the tissue fluids themselves and therefore only when a stable covering is provided.

Minimum disability during healing can be provided in several ways. For instance, infrequent visits to the doctor save much time for the ambulatory patient to work. A dressing, if possible, should not be too bulky but it must be bulky enough and firm enough to splint the part sufficiently to avoid all friction and bulky enough to avoid soiling from the natural discharge of the burn. Levenson and Lund[11] who were stimulated to study this aspect of burns by the very important animal experiment of Glenn, Gilbert, and Drinker[21] believe that in certain burns of the hand the prevention of swelling by a plaster cast prevents formation of abnormal deposits of fibroblasts in the tissues and that hands treated in this way have returned to normal function more rapidly than hands treated by other methods.

Major Burns

The principles underlying the treatment of major burns (all burns larger or deeper than second degree burns of under 5% of body area) are well stated by Whipple.[22] The problems of treatment of the surface are complicated by the very severe systemic effects of these burns that must be treated prior to or at the same time that the burn is treated. As Pack and Davis[23] have said: "It is wise counsel to advise the immediate general treatment of the patient rather than the burned area. It is penny wise and pound foolish to consume invaluable time in applying perfect local dressings, while the patient is sinking into irrecoverable shock." To treat a major burn takes planning and team work. Excellent directions for such team work have been described by Gurd [24] and by Harkins.[25]

Shock

The main reliance in the treatment of burn shock should be plasma. Electrolyte should be used only to alkalize the urine,[26] or to make up definite deficiencies in electrolyte that are due to known losses. Morphine should be given rather cautiously for pain[27] and heat should be used more cautiously than it has been used in the past.[28] Although Blalock[29] made definite estimations of the great loss of plasma from the circulation into the local tissues in severe burns over ten years ago, it was only since plasma became available that it was found that some cases can lose twice their original plasma volume in this way in the first twenty-four hours if they are kept alive by giving sufficient plasma rapidly enough.[26] Because of this loss, plasma should be given early and freely. There are two guides to dosage. One is by using a "surface area" formula which gives a fair estimate of the requirements during the first twenty-four hours. The other is by a hemoconcentration formula which gives values that indicate immediate needs. One "surface area" formula is to give 100 cc. of undiluted plasma for each 1% of area involved above 5%.[26] Another formula is to give 50 cc. of plasma for each 1% of area.[25] Hemoglobin and hematocrit determinations should be started at once and repeated every two hours. The blood pressure should be determined at least hourly. In general, hemoconcentration precedes a low blood pressure, but if the blood pressure is low, at least 500 cc. and probably 1000 cc. of plasma is needed at once. To use the hemoglobin or hematocrit as a guide several complicated formulas have been recommended. Harkins' simple formula[25] is, however, the most practical and useful. It is to give 100 cc. of plasma for each point the hematocrit is above 45 or 50 cc. for each point the hemoglobin is above 100. When using this formula, it must be remembered that it only indicates immediate needs. If plasma loss continues, later determinations may indicate additional amounts. In desperately shocked patients, the ordinary gravity administration of plasma does not allow rapid enough administration and plasma may need to be given through a large needle under pressure. Some cases are burned very severely at all the usual sites for vein puncture. In such cases, it will frequently be possible to administer plasma by femoral vein puncture, a technique

that should be better known.[25] In any case, the treatment of burn shock needs a considerable degree of clinical judgment as other factors enter into the picture besides purely the surface area involved and the degree of hemoconcentration. Some feeble patients apparently have no capacity to concentrate their blood.[26] There is also a variation in the plasma loss according to the area burned, its location and depth. In so far as possible, the plasma needs of a patient should be anticipated so as to prevent shock rather than treat it.

Early and Late Complications of Burns

The earliest complication of burns is hemolysis of red blood cells and hemoglobinuria. It only occurs with severe burns. Patients with such burns should be catheterized at once and hemoglobin sought in the urine. Also the first blood specimen taken for hematocrit determinations should be used to test for hemoglobinemia. If either hemoglobinemia or hemoglobinuria are present, the patient should be alkalinized with intravenous injections of 40 cc. of 1M lactate to each 500 cc. of plasma or an equivalent amount of sodium bicarbonate. As soon as an alkaline urine is established, the sodium lactate administration should be stopped. Shen and Ham[30] have shown that the source of the hemoglobin is probably from red cells burned within the capillaries of the burned skin, but its importance is that hemoglobin may be precipitated in the kidney tubules by the usually very acid urine found in burned patients and this may cause damage to the kidneys and lead to oliguria.

Other complications are azotemia, marked increase of nitrogen output in the urine, hypoproteinemia, and anaemia.[31] Usually these do not start until 24 to 48 hours after the burn. There is no specific treatment for the azotemia and azoturia except to maintain fluid balance without flooding the patient with salt. One should, however, keep in mind that azotemia and azoturia indicate a real breakdown of protein tissue and this loss must be made up in the food promptly. This loss, the demand for tissue regeneration, and the loss of protein from the surface in the form of plasma and pus is so great that the available protein stores may be depleted. As a result the plasma protein level decreases to extremely low levels, and the patient's weight falls off rapidly. This is a very serious circumstance that cannot be corrected by plasma or whole blood administration and occasionlly not by ordinary high protein diets because large enough quantities of protein cannot be given in this way for long enough periods of time. The solution for this situation is forced feeding of a high protein, high vitamin diet given preferably by stomach tube and supplemented by amino acids given through the tube or intravenously. The amount of protein needed may exceed 300 grams (dried weight) per day or the equivalent of about four pounds of steak per day.[31] The anaemia of burns does not respond easily to iron. Multiple whole blood transfusions are needed. In some cases as many as 25 transfusions of 500 cc. each have been given to patients within two or three months[31 32] with a successful outcome, but there are others in which even multiple transfusions do not control the anaemia.[33]

Infection and Surface Treatment

In spite of what has been written in the past, infection is a very small problem in large second degree burns if they are treated as indicated earlier in this paper under the treatment of minor burns. But infection is universal in cases of third degree burns and always serious in large third degree burns. These should also have bulky dressings over simple ointments and the dressings should be changed infrequently and should act as splints. Owens[34] gets excellent results using pressure dressings without any ointment, substituting saline compresses for ointment compresses as the inner layer. This is very important because it shows the unimportance of ointment and the importance of the dressing. Leaders in the study of burns, both civilian[2 3 4 5] and in the services[1] are rapidly giving up escharotics and turning to simple ointments for major burns in spite of the fact that the very recently published Military Surgical Manual V contains a section on tannic acid treatment. For instance, Churchill[35] from North Africa writes with obvious pleasure of finding simple boric ointment used at the front there.

Orr[36] has shown that infected compound fractures encased in plaster and packed open do well. Trueta[19] has used this treatment extensively under war conditions. Glenn, Gilbert, and Drinker[21] and Barnes and Trueta[37] have shown in animals that the flow of lymph from burns is greatly decreased, the blood flow remaining normal, in the experimental animal if the burn is encased in a close fitting plaster and that healing is better than when no plaster is used. As mentioned above, Levenson and Lund[11] have used this treatment successfully in humans. Such a plaster should be nearly skin tight, must enclose the tip of the extremity, and if possible, extend above the injury proximally, and must fit evenly. They have been applied and the patient allowed to go home and return for removal. They

should not be bivalved and should remain in place for two to three weeks. In applying the plaster, the burn is first covered with a layer of sterile vaseline gauze and the dressing should be put on under strict sterile operating room conditions. Then a thin layer of dry gauze is added and a nearly skin tight plaster put over this. The plaster should be just thick enough to avoid cracking later.

Chemical Prevention of Infection

Sulfanilamide, sulfadiazine, sulfathiazol, sulfaguanidine, propamidine, and penicillin are the most recent chemicals used locally to control infection in burns. References to this work are given in a recent review article.[38] These have been powdered on, put into ointments or creams, or incorporated into sprays or into preformed films. Although good results have been claimed for each of these methods none of them is useful unless all the other conditions of treatment are ideal and then, in the author's opinion they are rarely necessary. It is wise, however, to give sulfadiazine by mouth in full doses in the early period of a severe burn, but not starting before the kidneys have commenced to secrete urine.[26] In giving the drug by mouth one can regulate the dose easily, whereas surface applications have at times resulted in definite over dosage.[1]

Skin Grafting

Areas of granulation should be covered with split thickness grafts in wide sheets at the earliest moment. Of course, slough has to be out of the way and the patient's general condition must be good. It was formerly thought that any infection present on the granulations would prevent successful taking of such grafts. It is now thought that the patient's condition and the technical factors of the graft are more important.[3] There must be no hypoproteinemia, vitamin deficiency, anaemia, nor marked fever. For large areas, the Padgett Dermatome is a great help in cutting the grafts. The grafts should be sewed in place and absolutely fixed under an elastic pressure dressing. A cast should usually be employed over the dressing if the graft is on an extremity. Excellent descriptions of grafting procedures may be found in the Military Surgical Manual V[39] and in the recent paper by Cannon.[40]

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ACUTE ANTERIOR POLIOMYELITIS

(The 1943 Epidemic)

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BETWEEN January first and September fifteenth, 83 cases of poliomyelitis were admitted to the Charles V. Chapin Hospital. Of these, 69 are still under treatment in the hospital. The first case of the year was of the bulbar type and was admitted in January. This is frequently observed in epidemic years. In June, 2 more cases were admitted, but it was not until the third week in July that cases appeared in epidemic numbers. The admissions for July totaled 8 and for August 47. During the first three weeks of August, the number of daily admissions ran closely parallel to the epidemic of 1935 at which time over 250 cases of poliomyelitis were admitted to this hospital. However, during the last ten days of the month there was a relative decrease in admissions and during the first two weeks in September, only 25 cases were admitted. This indicates that the present epidemic is definitely subsiding.

Poliomyelitis has been prevalent in almost every state in the country. The United States Public Health Service reports 5,887 cases during the first 35 weeks of the year ending September 4. In the same period in 1942, there were only 1,902 cases. With the passing of the summer months, it is expected that the incidence of the disease will drop markedly.

Of the 83 admissions, about one-half came from Providence and the rest from various cities and towns in the State except for seven cases which came from communities in nearby Massachusetts. The disease has been most common in children. There were only 7 cases above the age of 20 years. There have been 3 deaths, all of whom were adults, giving a case fatality rate of 3.6%. This is below the usual rate of 7% to 10%.

The Kenny treatment has been instituted and every patient given its benefit. This treatment is time-consuming and has taxed the facilities of the hospital to the limit. The epidemic, coming at a time when general conditions are difficult at best, increases our problems manifold. There has been a shortage of personnel and equipment. A short time ago, an appeal was made to the public for washing machines after repeated efforts to get them through dealers proved futile. The response was gratifying and there is now enough of this necessary equipment. Woolen material was also scarce, but hospitals, hotels, and private schools donated or sold us their old blankets.

Under the efforts and guidance of Dr. William A. Horan, the State has aided by furnishing trained personnel for the technical care of the patients. Miss Dillon, director of the District Nursing Association, in cooperation with Dr. Horan, arranged for some of her nurses to receive instructions for the giving of hot pack treatments and then loaned us their services. The treatment of all patients has been under the personal direction of Dr. Horan. The resources of the hospital have been devoted almost entirely to the care of poliomyelitis cases. It is always fortunate that epidemics of this disease occur at a time when other infectious diseases are at a low ebb. It has been only as a result of the dauntless perseverance and untiring effort of our reduced and already overworked staff of nurses, augmented by the complement of district nurses, that we have been able to meet this crisis. The manner in which they have met the situation is highly commendable. Nevertheless, there is need for more nurses, both graduates and students, ward maids, porters, and other personnel necessary for efficient management of a ward.

It is too early to evaluate the result of the Kenny treatment. The hot packs, which should be given as soon as the diagnosis is made and continued until the muscle spasm has subsided, seem to have been very effective in releasing the spasm as well as relieving pain. Patients appear to be more comfortable and contented than with the old form of immobilization. Muscle re-education under the Kenny technique is meticulous and time-consuming. It requires a specially trained technician who possesses, besides skill, patience and interest in the welfare of the patients.

The Kenny treatment is new with us, as well as with many other hospitals in the country, and imposes a great responsibility on all concerned to see to it that it is practised according to the conception

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TEN YEAR STUDY OF MATERNAL MORTALITY

Report of the Committee on Maternal Mortality of the Rhode Island Medical Society

SINCE January first 1932 the Committee on Maternal Mortality of the Rhode Island Medical Society has surveyed the deaths of all women whose death certificates filed with the State Department of Health make mention of pregnancy, labor or the puerperium.

Each death has been investigated by a physician representing the committee. The investigator has interviewed the physicians signing the death returns and when a death occurred in a hospital has gone over the hospital records. When the returns for the year were all in and the survey complete the committee's representative has made his report to the committee and each individual case has been discussed to determine if, in its opinion, the cause of death as appearing in the death return was correct and the death properly classified according to the International List of Causes of Death. The maternal mortality rate in 1932, the first year of the survey was 5.7 per 1000 live births. In 1942 it was 1.9, a drop of 66 2/3%. The committee claims no credit for this gratifying reduction except for its share in increasing the interest in obstetrical subjects which this and similar surveys have stimulated the country over.

The statistical material accumulated over these ten years if buried in the committee's files is sterile. The discussions by the committee have been of great educational value to its members. In order to share with the profession the educational value of this material, the committee has each year made a report to the Society and for several years conducted special conferences to which the profession has been invited. Some of these conferences have been well attended; others have not. The committee is unanimous in its conviction that it would be futile, under present conditions, to try to hold any such conferences this year. It decided, therefore, to publish in the JOURNAL from time to time significant case reports with such comments as seemed appropriate.

The cases reviewed by this committee fall into three classes:

(*1*). Cases in which the causes of death were non-obstetrical and pregnancy was only a co-incidental condition. Included in this class are cases of acute appendicitis in early pregnancy, mastoiditis with meningitis, poisoning, cerebral haemorrhage without a super-imposed toxaemia in patients with hypertension of long standing and other fatal maladies to which pregnant women are subject along with their non-pregnant sisters and husbands and brothers.

(*2*). Cases in which pregnancy was complicated by a pre-existing condition or an acute intercurrent disease and while not the primary factor in the fatal outcome was a contributory cause and hastened a death that might have been delayed if the patient had not been pregnant. In chronic heart disease, chronic nephritis or so called essential hypertension, a mild toxaemia of pregnancy which in an otherwise normal patient could be controlled may run a fatal course, especially if the patient or her physician is not alive to the dangers inherent in these conditions. Pregnant women, while probably not unusually susceptible to streptococcus infection, if they are infected seem to be less resistant than non-pregnant women. The mortality of scarlet fever in pregnancy is high and in the influenza epidemic of 1918 the mortality among pregnant women approached one hundred percent.

To determine in these cases whether the deaths should be classified as obstetrical or non-obstetrical is often difficult and sometimes impossible. The committee has tried not to be swayed in its judgment by its natural desire that Rhode Island should make a good showing in the maternal mortality reports published each year by the Maternal and Child Welfare Division of the Department of Labor. It may be laid down as a guiding principle that any condition which anti-dates conception and makes the patient incapable of the normal function of reproduction (*provided always* that the course of pregnancy and labor is otherwise normal) is the cause of death and such a death should be classified as non-obstetrical.

(*3*). In the third class fall all those deaths resulting from diseases directly associated with pregnancy such as placenta praevia, separated placenta, post partum haemorrhage, toxaemia of pregnancy, puerperal sepsis, embolus and deaths following obstetrical operations. They must be classified as obstetrical deaths even though they are complicated by some pre-existing condition.

The following cases are examples of the three classes of cases described.

Class 1. *Primigravida*. Age 43. Right salpingo-oophorectomy and appendectomy January 9, 1935. Diagnosis:— Graafian cyst of ovary and chronic appendicitis. Blood pressure at that time was recorded as 162/102. First seen by attending obstetrician November 26, 1937, having gone over her menstrual period but a few days. Her blood pressure was exactly as recorded three years previously 162/102. Urine negative. The patient was seen and examined every two weeks from that date to May 16, 1938. The systolic pressure was at no time over 170, or 106 diastolic. Only once was albumen present and then only the slightest possible trace. There were no complaints. Due the first week in September. She arose the morning of May 28 feeling as usual. Before she had dressed she cried out with an excruciating pain in her head. She lay down and was seized with convulsive movements of the left side. Her condition was reported to the doctor who without seeing her, ordered her removal to the hospital. She was admitted to the hospital from the ambulance at 8 A.M. Temperature 98. Pulse 72. Respiration 20. Blood pressure 160/98. Catheterized specimen showed specific gravity 1006, albumen 0 — sugar 0. No casts or red blood cells. She was deeply comatose. Right eye deviated to right. Pupils rather small (morphia). Fundi showed no definite abnormality. Deep reflexes lively and equal. No pathological reflexes. Right limbs flaccid, left exhibit tonic spasms. Little if any stiffness of neck. Spinal puncture obtained bloody fluid under abnormal pressure, a mixture of blood and spinal fluid. Patient died at 8.08 P.M.

Diagnosis: — Massive pia - arachnoid haemorrhage on basis of congenital aneurism or arteriosclerosis. NON OBSTETRICAL DEATH.

Class 2. *Primigravida*. Age 36. At seventeen had tonsillitis which was followed by "kidney trouble". Since that attack her blood pressure was elevated but the urinary findings had been normal. Throughout her pregnancy the blood pressure had been 150/90 to 160/90. Otherwise apparently well. Two days before admission on December 10, 1942 she had a "slight cough and chest cold". Ankles showed swelling for the first time. On day of admission she developed headache, spots before the eyes and vomiting. Two convulsions. Morphia gr. ¼. Transferred to the hospital by ambulance. Blood pressure on admission 170/80. Temperature 100, pulse 88, respiration 18. Urine showed heavy trace of albumen and many waxy and granular casts. Uterus size of six and a half months pregnancy. Sedative and dehydration treatment instituted. December 11 — N.P.N. 50 mg., creatinine normal. No headache. Less edema. December 12 — N.P.N. 74, blood pressure 210/110. Membranes ruptured artificially. December 13 — blood pressure 200/100. Albumen heavy trace. Many casts, no red blood cells. December 14 — x-ray showed a "single foetus . . . nearer six than seven months size". December 16 — seven hour, forty-five minute labor. When two fingers dilated a hand prolapsed into vagina. As soon as dilatation of cervix was complete a three pound two ounce stillborn foetus was easily delivered by low forceps. Foetal heart had been heard ten minutes before delivery. Normal expulsion of placenta was followed by a moderately large blood clot. No excessive bleeding. Three hours before delivery patient had a chill and the temperature rose to 103° by rectum. Slight convulsion lasting two minutes a half hour before delivery. Immediately after delivery patient went into circulatory collapse. Coramine, oxygen, 500 c.c. 5% glucose solution and 255 c.c. of blood plasma intravenously were ineffective and patient died two hours and a half after delivery.

Autopsy:— "Toxaemia of pregnancy (clinical): acute interstitial pneumonia; acute myocarditis (interstitial); acute glomerular nephritis; haemorrhagic and focal necrosis of liver." Cause of death: Eclampsia. OBSTETRICAL DEATH.

Class 3. *Para 3*. Age 25. Previous history irrelevant. Two normal pregnancies and labors. Nine prenatal visits; first October 23, 1937; last March 3, 1938. Blood pressure and urine normal at each visit. No bleeding. Due March 18. Admitted to a hospital March 20 at 6:20 P.M. About 4 P.M. had passed a small amount of blood mixed with mucous, not enough to soak one vulvar pad. No bleeding on admission. Not in labor. Uterus soft. Breech presentation. Floating. Fetal heart 152 in right upper quadrant. About 10:30 P.M. there was a slight trickle of blood for fifteen minutes. Operating room ordered prepared for Caesarian section. She asked for bedpan. While on pan, vomited and

passed four and a half quarts of blood, filling pan and forming a large pool in the bed. Transferred to operating room. Intravenous saline. Operation started at 11:40 P.M. No pulse or blood pressure obtainable. Low flap Caesarian section. Complete placenta praevia. Uterus atonic. Supra-vaginal hysterectomy. 1000 citrated blood. Temporary improvement. Systolic blood pressure 70. In spite of supportive and stimulative treatment the patient died two hours after operation and four hours and five minutes after onset of active bleeding.

Cause of Death:—Placenta Praevia; haemorrhage. OBSTETRICAL DEATH.

These first two cases illustrate the hazards of hypertension. Both patients had an elevated blood pressure with negative urines for many years before they became pregnant. Both were primipara over thirty-five years of age. The first patient died of a cerebral haemorrhage without developing any signs or symptoms which could be attributed to the pregnant state. The blood pressure remained at the same level before and after conception; the urine remained free of albumen and casts. Toxaemia of pregnancy was not super-imposed upon the chronic hypertension. The committee considered that the pregnancy was merely co-incidental to the chronic hypertension which frequently results in cerebral haemorrhage and classified the death as non-obstetrical.

The second case, in marked contrast, showed unmistakable signs and symptoms of a super-imposed fulminating toxaemia — edema, increased hypertension, headache, spots before the eyes, vomiting, albumen and casts in the urine, convulsions. This case was classified as an obstetrical death due to toxaemia of pregnancy.

It cannot be too often pointed out that a large percentage of deaths from toxaemia occur among patients who show an elevated blood pressure when they appear for the first time in the doctor's office. The blood pressure is normally low in pregnancy. Any systolic blood pressure above 130 or diastolic above 70 should put the doctor on his guard and he should insist on frequent visits to his office. In these patients a rising blood pressure and albumen and casts in the urine are of the gravest import.

The third case needs little comment. It was obviously an obstetrical death. It does illustrate the possible significance of vaginal bleeding in a pregnant woman and the importance of immediate removal to a hospital however slight the bleeding may be. It made no difference in this case but if the obstetrician had temporized the patient would have died at home and he and the patient's family would always have had the feeling that perhaps her life might have been saved if she had been in a hospital. Rarely does the first bleeding from a placenta praevia develop so late in pregnancy and rarely is the haemorrhage so overwhelming but such cases do occur and the wise physician will protect himself and his patient by insisting upon hospital care in any case of vaginal bleeding in pregnant women.

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of its originator. It would be unfortunate if we were to obtain poor results and therefore abandon it, when actually the cause may be our inability to properly carry out the treatment as a result of the lack of skilled personnel or proper equipment.

The RHODE ISLAND MEDICAL JOURNAL

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1-A CLASSIFICATION FOR DOCTORS

Our latest information from the Rhode Island Headquarters of the United States Selective Service System relative to the classifying and preparing for induction so-called pre-Pearl Harbor fathers is as follows: (Doctors up to 45 years of age, if available, may be subject to induction.)

> "The procedure is the same with doctors as it is with all other registrants. When a doctor's Order Number is reached by his Local Board, if he is certified as available by the State Procurement and Assignment Committee, he will be ordered for his local board physical examination. This will probably consume at least 5 days.
>
> "He will then undoubtedly be reclassified by his Local Board at their first meeting following the screening examination, and he will then be notified by his Local Board of his new classification. All registrants have a period of 10 days from the date of their classification in which to appeal if they care to do so.
>
> "If the classification is not appealed, a registrant is then available for induction. Under the Regulations, he will receive 10 days notice of induction. Upon the day he is inducted, if he is accepted for the Army he will be given 21 days furlough. If, however, he is selected for the Navy he will be given only 7 days furlough, or if selected for the Marine Corps, 14 days."

It therefore appears from this ruling that when a physician receives his order for his local board physical it is a pretty good indication that he will be inducted within a comparatively short time. Under the present policy no registrant is entitled to postponement of induction for the purpose of applying for a commission.

Thus, if a physician does not apply for a commission until he has been ordered for his local board physical examination, his chance of receiving a commission prior to the date of his actual induction is quite remote.

All doctors who are in doubt as to whether or not they have been classified "available" should immediately contact Halsey DeWolf, M.D., chairman of the State Procurement and Assignment Committee, at his office at 305 Brook Street, Providence.

FERDINAND L. TITSWORTH

The RHODE ISLAND MEDICAL JOURNAL records with deep sorrow the death of Ferdinand L. Titsworth, President of the E. A. Johnson Company which has printed this publication since its inception in 1917.

Mr. Titsworth was the son-in-law of Mr. Johnson and joined the Company in 1922, therefore he was intimately connected with the JOURNAL for four-fifths of its life. Like his father-in-law before him he had a broad acquaintance among medical men and entirely aside from the business aspects he took a genuine interest in the problems confronting medical men and their publication.

He entered enthusiastically into the discussions regarding the new format which has distinguished the last few numbers, contributing numerous valuable suggestions.

The statement has come from a source peculiarly fitted to speak on such matters that under his direction the typography and layout of the JOURNAL has been developed so that it is probably without equal in these respects among medical journals of the country. All of us connected with the RHODE ISLAND MEDICAL JOURNAL mourn the loss of our friend and helper.

MODERNIZING OUR HEALTH LAWS

THE CONCERN which has been widely expressed in recent months relative to the care of the health of the public during the present war period while many of our doctors and nurses are serving with the armed forces should serve as an impetus for prompt action by the Commission recently named by the Governor to study the public health laws of Rhode Island. The special commission of eighteen members, which includes six doctors of medicine, has until April 12, 1944 to make its recommendations, but in view of present conditions it should seek to pursue its study for an earlier report date.

The Commission, created by the General Assembly at its 1943 session, has been delegated, among other things, to make recommendations "for complete modernization of the health laws in keeping with the most recent innovations and tried practices of other states." We can think of no better starting point in a general approach to the problem than consideration of the establishing of legal qualifications for those who are to enforce the health laws and sanitary code which the Commission seeks to clarify and coordinate.

The use of a single executive to head the health department is in line with the movement of the past twenty-five years looking toward a greater integration of the state's administrative structure under a responsible governor. Thereby the chief executive in eighteen states, including our own, is responsible to the legislature and to the people for the conduct of the health department activities. In nine of these eighteen states the governor's appointment of the health director is subject to the approval of the Senate, but this check does not always work to the advantage of public health, for a governor, mindful of his own legislative program, is apt to name a director on the basis of his friends in the Senate rather than for his skill as a health administrator.

Therefore the safeguard should be provided in the form of recognition of the importance of proper training and experience as a qualification for the post of public health administrator. Presently every state has a doctor of medicine as its health officer. In 38 states the principal requirement is that the director of health shall be a physician, and in more than 20 states training or experience in public health is a necessary qualification. While experience would indicate that the selection of men with medical training is usually desirable, yet proven executive ability and experience in public health administration also must be considered.

Six years ago the United States Conference of Mayors made this observation when it recommended to the cities of the nation standard qualifications for health officers following an exhaustive study by its National Health Officers Qualifying Board consisting of leading national public health authorities. The *minimum* requirements for health officers in cities of 500,000 population as stipulated by this Board consist of:

> Graduation in medicine from a Grade A medical school and not less than 6 years' full-time experience in public health work, 3 years of which must be in a responsible administrative position 2 of the 3 years of general experience may be substituted by a course in public health of not less than one scholastic year in residence at a recognized institution of learning.

The Providence Medical Association sought inclusion of legal qualifications for the city health officer of Providence when the new city charter was drafted in 1941, but it was unsuccessful in its effort, due in no small measure to the fact that the State had never established legal qualifications for the director who heads all public health activities for our communities. The same weakness was exposed two years ago in the appointment of the local town health officers, with seven towns assigning the position to laymen who had no apparent background in public health administration. Today there are eight towns with laymen as health officers, all occupied in other daily work having little or no bearing on the safeguarding of the general health of the public, and all inadequately trained to co-

operate with the medical profession in the constant vigilance against the spread of disease which might become epidemic during the war period.

It is thus readily apparent that if we are to enforce any health laws effectively throughout the state we must recognize the independence of health officer appointments from the sphere of politics. One definite step would be the listing of legal qualifications for all health officers whether state, city or town. Another would be to consider the advisability of having the health officer, particularly on the state and city levels, serve for a longer term than that of the appointing agency in order that he may advance a long range health program without political interference. The present generation has a deeper insight to medical care and hospital service than any previous one, and it will respond readily to any sincere effort towards strengthening the safeguards for good health. The possible reactions of political groups to the recommendations of the Special Health Laws Survey Commission should therefore be disregarded as the commission fulfils its obligation to the citizens of Rhode Island.

TUBERCULOSIS IN PROVIDENCE

The severity of tuberculosis in a community is generally measured by the death rate of the disease. Alarm and concern is proportionate to the rise and fall in mortality. We have reason to believe that the death rate for the current year will be low, for since the inception of systematic tuberculosis control in 1904, it has steadily declined. True, there has been an occasional year when the number of deaths was greater than the previous year, but, such a rise has seldom been sustained. The trend usually returns to its downward path within a short time.

In reviewing some of the mortality statistics of recent years we find that in 1934 there were 127 Providence residents who died of tuberculosis. In 1935 there was a sharp increase in deaths to 154 and this level was maintained through 1936 and 1937. The following year the downward trend reasserted itself and the mortality dropped to 127. The decline continued in 1939 and 1940 when the deaths respectively were 109 and 99. In 1941, however, there was another sharp temporary increase in the mortality to 133. This rise, unlike that of 1935, was not sustained and promptly fell in 1942 to 117. The first six months of 1943 show a half year mortality of 52. It is quite obvious that we may expect 1943 to show a substantial decrease in tuberculosis mortality over the previous two years.

In a recent communication the National Tuberculosis Association has stated that the trend in tuberculosis in Providence substantiates the opinion that increases in tuberculosis mortality are not sustained. It is gratifying to know that in spite of the occasional discouraging increases the more effective control of the disease in our community is asserting itself.

One would expect the morbidity from tuberculosis to be a more important yardstick than the mortality. However, the known incidence of the disease does not in any way aid us in determining the morbidity. Many new cases are reported but the number of these which show active disease is not always readily determinable. It is hoped that the new card which the State Department of Health has recently made available for the reporting of tuberculosis will aid us greatly in determining which of the cases are active.

The lure of high wages and permanent work has won many active, unstable, partially cured and apparently arrested cases of tuberculosis to jobs which are not commensurate with the worker's ability. It is sad to realize that the advice of those who know only too well the end result of these foolhardy excursions into difficult jobs is so lightly taken. Would that we were able more effectively to point out to these patients that the return is poor for those who would trade health security for economic security! With this group of patients the rainbow of economic security is all too short-lived, for it has been proven, time and time again, that they cannot sustain good physical being unless they follow sound medical opinion. Under such circumstances it would be imprudent not to anticipate an increase in the number of active cases of tuberculosis during the present difficult period. A coincidental rise in mortality should follow such an increase. However, if the history of this disease repeats itself, we may well expect the post war years to show the gradual and eventual decline to the irreducible minimum.

It is an observation that the majority of active cases of tuberculosis are referred to our tuberculosis clinics and hospitals by alert private physicians. The credit must largely flow to this group for the continued decline in tuberculosis. Their obligation in discovering these cases is proportionate to the incidence of active cases in the community.

In as much as there is an ever increasing number of patients suffering from the fatigue states and nervous disorder (so readily attributed in these

times to overwork or to the severe emotional strain which personal contact with war gives) the difficulty is posed for some private physicians to decide which patients with these classical early symptoms of tubecrulosis should be x-rayed. One is almost tempted to suggest that all such patients should have chest x-rays.

GALLOPING THE POLL

When Congress re-convened on September 14 Senator Robert F. Wagner asked for unanimous consent to having printed in the Appendix (of the Congressional Record) a statement he made a month previous, on the eighth anniversary of the original Social Security Act, relative to his new social security bill S. 1161. In the same connection the Senator asked to have printed also a Gallup poll "showing overwhelming public approval of this means of pay as we go now for post war social security" which he claimed confirmed polls taken by other organizations and periodicals.

The Gallup poll the Senator referred to was the coast to coast survey of the American Institute of Public Opinion which asked:

"At present the social-security program provides benefits for old age, death and unemployment. Would you favor changing the program to include payment of benefits for sickness, disability, doctor and hospital bills?"

The vote is:	
Yes	59%
No	29%
Undecided	12%

All those who favored the program were then confronted with the fact that this would mean an increase in the amount of money deducted from their wages or salaries. They were asked whether they would be willing to accept this larger deduction:

"Would you be willing to pay (or have your husband pay) 6% of your salary or wages in order to make this program possible?"

The vote of the *59%* approving the program divided as follows:	
Yes	44%
No	11%
Undecided	4%

Even a casual reading of these figures should assure the reader that the New York Senator's "overwhelming public approval" indicates a proficiency in verboseness on his part that is not compatible with fundamental mathematics. And we shudder to think what would happen to the surviving 44% of the "Yes" votes if a third question were to be propounded to ask:

"Would you be willing to pay 6% of your salary or wages with the understanding that your choice of doctor and hospital would be limited by regulations imposed by the Government, thus giving you no assurance that you would get the high type of medical service you now have available?"

CHRISTMAS OVERSEAS

In spite of the fact that some over optimistic war correspondents have expressed the hope that the European conflict may be ended by Christmas there is little doubt that our doctors now abroad will be at their stations when the Yuletide season arrives. Hence those of us at home may well take note of the postal regulation that Christmas parcels for overseas will be accepted ONLY during the period from September 15—October 15 without an official request from the recipient.

As to what to send the soldier overseas. The Office of War Information has surveyed the ranks and has reported some interesting observations. The soldiers, according to OWI data, emphatically say they do NOT want cigarettes, assorted commercial packages of goodies, elaborate shaving kits, or food, except for a well-packed fruit cake. This may surprise many at home who do not know that even where cigarettes are most heavily rationed the men are allowed a pack a day, and in India the ration is 10 packs a week.

Soldiers in different combat areas do not want the same articles. For example, men in the European zone have reported a desire for medium-weight leather gloves, fountain pens, OD socks, and light shirts. In the China-Burma-India area reading material—books, magazines and clippings—rate highest as the best Christmas gift. Next in order of importance are fine razor blades, compact shaving kits, combs, smoking tobacco, sun glasses, and wrist watches. In Australia a good cigarette lighter with a supply of extra flints and wicks, fountain pens that won't leak at high altitudes, and pocket-sized books head the list. One item, according to the Army Exchange Service, which is "worth its weight in gold" in every zone is canned, vacuum-packed peanuts.

Most important gift of all is that message of encouragement from the friends at home. Every doctor here should accept it as a personal obligation to allot time from his busy day to send a letter to his colleagues out on the fighting fronts. The latest addresses of all men in the armed services are available through the Executive office of the Society.

R. I. HOUSE OF DELEGATES

Report of Regular Meeting Held on September 23, 1943

WILLIAM P. BUFFUM, M.D., *Secretary*

A regular meeting of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Thursday, September 23. In the absence of Dr. Michael H. Sullvian, president, Dr. James L. Wheaton, vice president, presided. The following motions were adopted:

Membership

The Secretary reported on the sentiment of the Newport Conference called by the President in August to discuss the question of state and district society membership, and he also read the recommendation of the Council asking that the House of Delegates recommend that each district society adopt a rule that all new members shall be required to join both the district and the State medical societies at the same time, and if membership ceases in one for any reason it will automatically cease in the other.

Following discussion of the motion, the House moved its passage unanimously.

Budget and Dues for 1944

The Treasurer submitted a proposed budget for the Society for the year 1944, showing an approximate income (based on an assessment of $10 per active member for dues) of $5,222.61, and an estimated expenditure of $11,468. He also reported that the Council recommended that the House of Delegates establish the annual dues in 1944 at $15 for each active member not in military service, with the understanding that an additional victory assessment of $10 be made on each active member not in military service on July 1, 1944, to meet the anticipated expense of the Society for the year.

The question was discussed briefly, and the House adopted the proposed budget and the recommendation of the Council relative to the assessment of dues for 1944.

Advisory Board to State O.P.A. Office

The Executive Secretary reported on the need for a medical advisory board to assist the State Office of Price Administration relative to problems arising from the medical certification for supplemental issuance of rationed commodities.

The Secretary reported the recommendation of the Council that the House of Delegates authorize the President to appoint a Medical Advisory Board to the Rhode Island Office of Price Administration to consist of three doctors who will serve with full authority to act for the Society.

The recommendation was adopted by the House of Delegates as presented.

Annual Meeting in 1944

The House of Delegates adopted a motion that the annual meeting of the Rhode Island Medical Society in 1944 be a two day meeting.

Shortage of Physicians

Dr. Elihu S. Wing, chairman of the Committee on the Shortage of Physicians, reported on the current problems facing his committee, and presented extracts from the latest national report of the Office of War Information relative to the protection of civilian health during the war period. He also cited the need for authorization for the Committee to further a complete educational program to acquaint the general public with the ways in which it may cooperate fully with the medical profession in the coming months.

The House adopted the recommendation of the Council that the Committee on the Shortage of Physicians be empowered to carry out whatever program of public education relative to civilian health that it deems best to cope with the shortage of physicians in the State.

War Participation Committee

The Secretary reported that the War Participation Comittee of American Medical Association had urged the appointment of a War Participation Committee in each State Medical Society. He further announced that the Council recommended to the House that it empower the President of the Society to appoint a Committee on War Participation, and until such time as the Committee is appointed the present Committee on Procurement and Assignment shall assume the duties of the War Participation Committee.



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The House of Delegates moved the adoption of this recommendation.

Maternal Health Program for Wives of Servicemen

The Secretary reported the receipt of a communication from the American Medical Association relative to the national legislation to provide funds for the emergency maternal health program for the wives and children of servicemen. He further stated that the Committee on Maternal Health, under the direction of Dr. E. S. Brackett, is making a complete study of the entire program. The House moved that the Secretary act as he deemed best for the interest of the Society in the problem, and that any action by the House of Delegates be deferred until such time as the report of the Committee on Maternal Health is presented. The motion was adopted.

Medical Economics Committee

The Secretary read the report of the Committee on Medical Economics as submitted by the chairman, Dr. Herman C. Pitts. The report was accepted and placed on file.

The Wagner-Murray-Dingell Act

The Executive Secretary, reporting for Dr. Herman C. Pitts and Dr. Emery M. Porter, presented a brief resume of an informal meeting of New England physicians held in Boston to discuss the Wagner-Murray-Dingell act providing for the expansion of the social security program to include complete hospitalization and medical care.

The House of Delegates adopted a motion that the Committee on Public Laws be requested to make a critical analysis of the Wagner Act for consideration by the Society, and that it cooperate with the other state medical societies in New England in any general discussion of the medical phases of the legislation.

State Legislative Problems

The Executive Secretary, reporting for the Chairman of the Committee on Public Laws, briefly discussed the need for consideration by the Society of state legislation to provide for an annual registration of doctors of medicine, and also for legislation to clarify the right to the use of the prefix of "doctor" in Rhode Island.

The House of Delegates adopted a motion that the Committee on Public Laws be asked to prepare proper legislation to provide for annual registration of doctors in the state, and also legislation to provide for the control of the title of "doctor" as applied to the healing art, and further moved that each district medical society be asked to appoint a member of its society to serve as a legislative officer to assist the Committee on Public Laws in the furtherance of its work.

Appointments

The President announced the appointment of Dr. Roland Hammond of Providence as Chairman of the Medical Defense and Grievance Committee, and Dr. Hartford P. Gongaware of Westerly as a Trustee of the Rhode Island Medical Library for a one year term starting January 1, 1944.

MILITARY ANNOUNCEMENTS

ASSIGNMENTS

LIEUT. ADOLPH J. NADWORNY, MC-Af, 36 OT Battalion, Carlisle, Pennsylvania.

TRANSFERS

MAJOR E. J. BERNASCONI, MC, to Station Hospital, Scott Field, Illinois.

CAPTAIN ERNEST W. BISHOP, 0-349372, to 58th Evacuation Hospital (S.M.), APO 4672, San Francisco, California.

CAPTAIN KENNETH BURTON to 1st Aux. Surgical Group, APO 4834, c/o P. M., New York, N. Y.

LIEUT. COMMANDER JAMES H. COX, MC, to Newport Naval Hospital, Newport, Rhode Island.

LIEUT. (j.g.) JOHN R. CRANOR, MC, USNR, c/o Commander Air Pacific, Fleet P. O., San Francisco, California.

CAPTAIN WILLIAM V. HINDLE to Lovell General Hospital, Fort Devens, Massachusetts.

LIEUT. MAURICE KAY to Station Hospital, Camp Blanding, Florida.

CAPTAIN J. T. KEOHANE to 91st Medical Battalion, Camp Livingston, Louisiana.

CAPTAIN WILLIAM MCINTYRE to 17th Medical Hosptal Ship Platoon (Sep), c/o 110th Station Hospital, APO 649A, c/o P. M., New York, N. Y.

CAPTAIN CLARENCE J. RILEY, 0399891, to Co. C., 556 SWA Bn., Med. Det., APO 612, c/o P. M., New York, N. Y.

LIEUT. COLONEL HAROLD ROGELL, MC, to 108 Station Hospital, A. P. Hill Military Reservation, Virginia.

LIEUT. (s) RAYMOND E. STEVENS, MC, USNR, to Naval Aviation Cadet Selection Board, Ferry Building, San Francisco, California.

PROMOTIONS

LIEUT. J. T. KEOHANE to the rank of Captain.

LIEUT. WILLIAM MCINTYRE to the rank of Captain.

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A true story of how a nine year old asthma sufferer finally obtained relief

B L , a nine year old boy, had been suffering from asthma for eight years. He had been pronounced incurable by specialists in many parts of the country.

His asthma was so serious that he had become allergic to most pollens and was also sensitized against many foods. He had spent most of his life under treatment.

Three years ago the family of this boy moved to New Mexico where they believed the climate of that state, beneficial to many asthma sufferers, might provide relief for their son. But again they faced disappointment.

It was then that the boy's mother recalled seeing a device at a clinic to which she had taken her son, that might bring him some relief from his suffering. Although not a cure for asthma, the device was reported to have given relief to another child similarly affected, by removing pollen from the air.

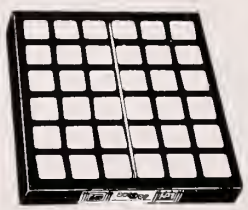
Obtaining a drawing, the boy's mother had a local carpenter build a simple unit. It comprised a wooden box-like affair fastened tightly over the open window of the boy's room. A Fiberglas Dust-Stop Air Filter was fitted in the end of the box closest to the window. Air was drawn through the filter, which strained out pollen, by installing a small electric fan inside the box.

After the home-made device was put in operation, the boy found real relief. For the first time in eight years he was able to sleep quietly at night.

So marked is the relief that he no longer has to be confined to his room, but stays there only at night or after exposure to pollen-laden air.

★ ★ ★

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INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., Chairman; Herbert E. Harris, M.D.; Stanley D. Davies, M.D.; Michael H. Sullivan, M.D.; William P. Buffum, M.D.

CONTROL OF THE COMMON COLD

IT IS ADMITTED that respiratory infections are responsible for more loss of time from industry than any other disease or group of conditions. In discussing some of the methods which are available for the prevention and control of cold infections, Dr. Chester S. Keefer, Wade Professor of Medicine, Boston University School of Medicine, and Director of the Evans Memorial, Massachusetts Memorial Hospital in Boston, has said that there is no completely effective method for the control of the common cold. In a paper read at the Fifth Annual Congress of Industrial Health held at the Palmer House in Chicago, January 11th to 13th, 1943, Dr. Keefer discussed in detail the use of the common cold vaccine. In summary the following excerpts are highlights from Dr. Keefer's paper.

"It is now agreed that the common cold is caused by a filtrable virus and that it is the most frequent of all respiratory infections. ***Epidemiologic studies disclose that the frequency of colds is between two and three dozen each year.*** It has been shown that the virus of this disease promotes and furthers infection of the respiratory organs by pathogenic organisms such as the pneumococcus, hemolytic streptococcus, staphylococcus and influenza bacillus.*** There are three main peaks of incidence each year; the first in January and February, the second in April and May, and the third in September and October.*** The epidemic in January and February is the most serious as measured by absence from work and severe complications. Infection is frequent in families, in schools, in industries and where overcrowding is common.

"The common cold is highly contagious and the incubation period is short, varying between twenty-four and thirty-six hours. The infected individual can transmit the infection to others only during the early stages of the disease; that is, during the first day or two after the onset of infection. The most infectious period is the first day.***

"Once colds become prevalent in any community, many susceptible people who are exposed to an infected person come down with the disease. The degree of susceptibility and resistance varies from one individual to another and from year to year.*** Resistance seems to increase with age, since there are fewer colds in the elderly than in the young.

"The common cold is due to a filtrable virus and that part of its action is to promote secondary bacterial infection of the respiratory organs.***

"We are almost wholly ignorant of the factors that promote the dissemination of a virus in any community and cause outbreaks of the disease. It is well established that colds are contagious and are spread by contact infection and probably by the air, but it is completely mysterious why there should be sudden outbreaks of the disease.*** There seems to be little doubt that** environmental factors are of importance but their precise role remains unclear."

Chilling and Temperature Changes as Factors

In discussing the role of chilling and sudden changes in temperature in the production of colds, Dr. Keefer referred to the work of Paul and Freese carried out in Spitsbergen and those of Paul on the nonmagnetic ship Carnegie. "In Spitsbergen which is an extremely isolated community in winter, it was found that an unfavorable environmental factor such as a sudden drop atmospheric temperature was not necessary for the development of an epidemic of colds. It was noted, however, that the arrival of the first boat of the shipping season was

continued on next page

INDUSTRIAL PHYSICIANS MEETING

A joint meeting of industrial physicians and industrial nurses will be held at the Medical Library on Tuesday, October 19, at 8:30 p. m., under the auspices of the Industrial Physicians Society of Rhode Island. The guest speaker for the meeting will be Robert Gillespie of the Walsh Kaiser Co., who is an associate member of the American Society of Safety Engineers and a member of the Engineering Section of the National Safety Council.

The meeting is open to all doctors of medicine and nurses in the State interested in industrial health.

usually followed by an epidemic involving the whole community in a short time. This suggests that the introduction of a virus from outside is more important than the climate. Also it was noted by Paul and Freese that trappers who fell through the ice did not develop colds during the winter and spring but did so only if such an accident occurred after the men had been to town in the summer and fall. Such observations suggested that sudden chilling of the body may bring on an attack in a person who has had a recent infection or a recent contact but only if such a condition accompanied the chilling.*** Exposure to cold may in some way activate the virus.***"

Prevention

Dr. Keefer further details the methods of prevention and pays particular attention to cold vaccines. He states, "Methods of preventing colds have been directed along several lines. It can be said at once that none of them are effective. Since it is as yet impossible to prevent the spread of the virus in the community, attempts have been made to increase the resistance of the host. Within recent years vaccines, vitamins and "hardening processes" have been investigated."

Cold Vaccines

"Since the common cold is due to a filtrable virus and the organisms included in the vaccines are now believed to be of secondary importance, it is not surprising that these vaccines, whether given by mouth or by injection, have been a great disappointment.*** It is generally agreed that the incidence of colds is no less following their use than in groups of nonvaccinated controls, and there is good evidence that these vaccines may produce little or no protection against diseases of the upper respiratory passages.*** In 1938 it was found that in a group receiving a polyvalent vaccine by mouth the incidence of colds was the same in the vaccinated as in the control group, and the same was true when Rosenow's streptococcus vaccine was used. In a third group receiving vaccine subcutaneously there were twenty-five per cent fewer colds per person than in the control group. This difference was noted during both years of the study and was considered statistically significant. Practically, however, these authors expressed the opinion (Diehl, Baker and Cowan) that this reduction of twenty-five per cent in the average number of colds in the group was not sufficiently great to justify the time and expense involved in carrying out the program. In the second report, appearing in 1940, it was concluded that in a group of cold susceptible students at the University of Minnesota there was no evidence that heat killed vaccine was of any value in preventing the common cold.

"As the virus of the common cold promotes the growth of micro-organisms in the respiratory passages, it might be hoped that vaccines made from these organisms would reduce the number of complications. Experiments designed to shed light on this question have been carried out by Dochez and his associates, and by Diehl, Baker and Cowan. The results have not been very encouraging. The former investigators studied a group of twenty infants in an institution and gave vaccine at weekly intervals over a period of nine months.*** There was no reduction in the number of simple colds or respiratory infections associated with fever in the vaccinated when compared with the nonvaccinated. Dochez and his co-workers concluded that the protection against febrile respiratory complications of a cold was incomplete and that the technic of carrying out such immunization was so time consuming and burdensome that this method did not seem promising for general use.*** On the whole, then, one can say without fear of contradiction that the results obtained from cold vaccines have been disappointing. The vaccines have failed to prevent colds, and they have failed to lessen the number of complications except when given repeatedly over a long period of time."

Conclusive Evidence Lacking on Vaccines

Dr. Keefer then in summary states, "To sum up it can be stated that vaccines containing the ordinary organisms found in the nose and throat are of no practical value in the prevention of colds. There is no conclusive evidence that they even shorten the course of a cold or prevent the development of secondary infections. It is also true that vitamins fail to prevent colds at least in a group of cold susceptible people. To date all other measures have failed to influence the frequency of colds and we are forced to the unhappy conclusion that at present there are no effective methods available for the prevention of the common cold."***

Role of Industrial Physician and Nurse

In view of the fact that a large number of drug manufacturers are sending detail men to the plants and offices of industry, interviewing representatives of industry, and 'by-passing' the regular medical departments and the nurse in the plant, these remarks should be of timely interest to physicians and nurses engaged in industry. It is the duty of the physician and nurse in industry to contact the

continued on page 219

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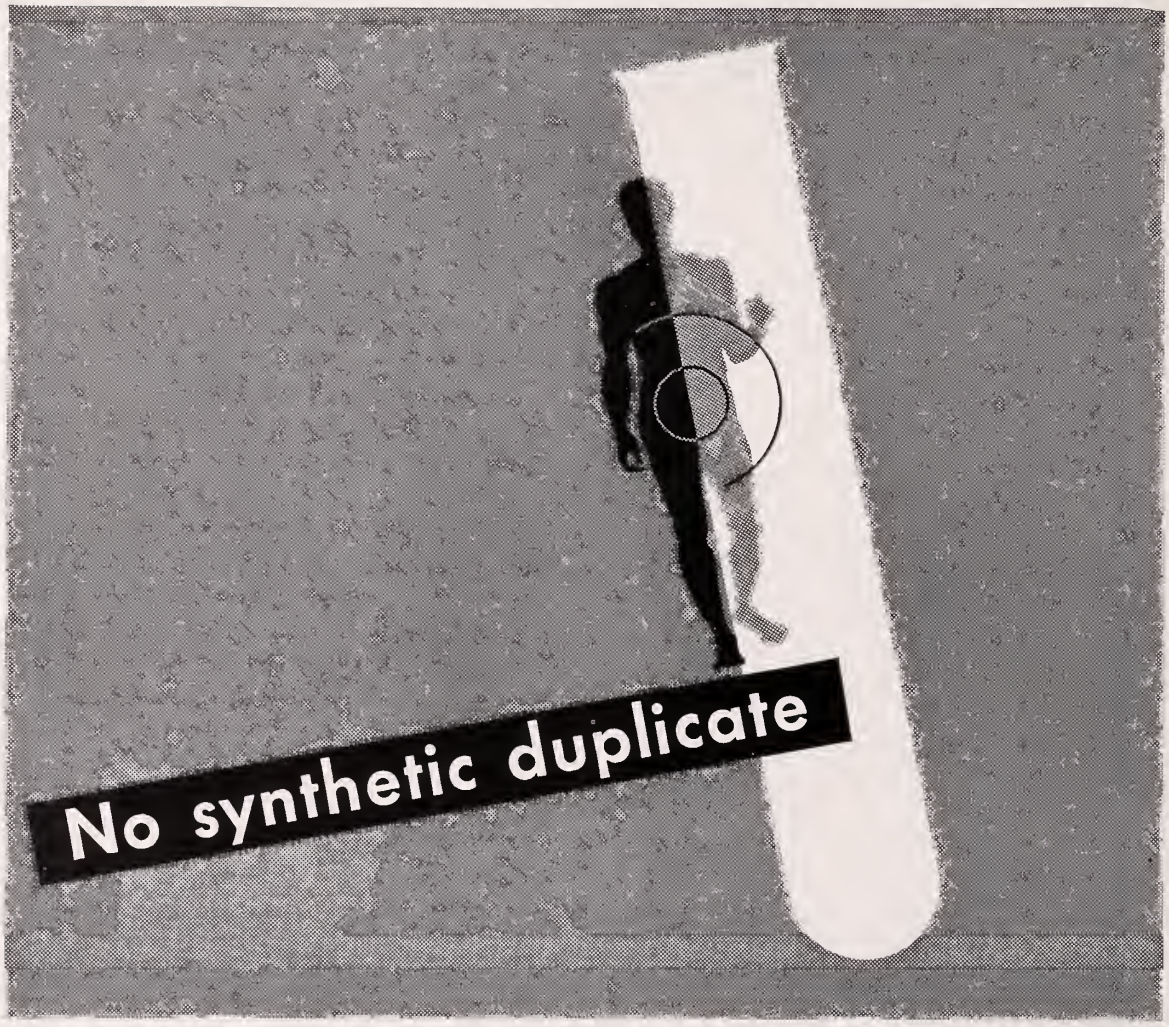
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NEWS FROM THE WAR FRONT

WITH THE 48th UNIT IN INDIA

A report of the Rhode Island Hospital Unit by Major Frank B. Cutts, MC, former Secretary of the Providence Medical Association.

Station Hospital,
A P O 628
c/o Postmaster, New York.

When I last wrote you we had just returned from a more or less Boy Scout sojourn in Tennessee. Since then a lot of water has passed under the bridge and under us. In fact, up to the present time we have travelled approximately 20,000 miles.

The longest part of our trip was in the main quite uneventful. We had daily medical conferences in conjunction with the two other medical units who travelled with us and brushed up fairly well on all phases of tropical medicine. Lt. Col.'s Lawson and Mahoney need have no fear of Hades if they should end up there by mistake. Their room was right over some steam tubes and they were thoroughly pasteurized most of the trip—only a person with advanced syringomyelia could stand on their floor with bare feet. We all learned a little astronomy on the beautiful clear star-lit evenings under the Southern Cross and countless other constellations.

After landing in India we took a good long train trip—about 25 m. p. hour—so we had plenty of chance to see the country. It was the dry season at that time and we went through vast arid treeless plains with native villages at frequent intervals. That standard of living is such that the share-croppers in our South would be veritable aristocrats in comparison.

We finally reached our destination on the edge of the jungle and got to work setting up our camp. We lived in tents and soon after we arrived it rained in torrents for ten consecutive days. Mud—slippery cream-like mud—was everywhere and was nearly slippery enough to ski on. However, we gradually made ourselves comfortable, gravel walks to the mess hall were built, an officers' club was arranged in one of the bamboo bashas and the general situation became quite pleasant. We made some elementary furniture out of rattan and bamboo. The weather cleared and there were many beautiful warm clear days with cool clear star-lit nights—and very few mosquitos at that season. A field of moderate size was found nearby and out of it was built a very useful softball field for exercises and recreation. Our medical work was minimal at this stage although we did attend rounds at a nearby general hospital and saw many interesting problems and had many stimulating discussions.

After a while bashas were built for us and we lived quite comfortably in them. Our existence was not bad at all then. Monkeys chattered at times in the nearby woods, jackals would howl at night and 6 or 7 cobras and banded Krait snakes were caught in the camp area but except for occasional episodes of excitement none of us were any the worse for their presence.

Finally somewhat more than 2 months ago a large portion of the unit packed up again and traveled for several days to our present location. When we first arrived it was really hot here—on several occasions getting up to around 118°. At night the metal bed frame would be too hot to touch with comfort and some of us found that sprinkling water all over the bed would cool it considerably by evaporation. Some of the boys blossomed out in khaki shorts—in fact, Bob Murphy's shorts took approximately 25 years off his appearance.

Now that the monsoons are well under way it's much cooler. It's quite a spectacle to observe how the arid country around here has blossomed out in the rains.

Our medical work has been active and interesting. In the medical service malaria has been the most prevalent disease. Some of the patients have had severe overwhelming infections with the falciparum plasmodium, coming in unconscious with innumerable parasites in their blood smears. Those with benign tertian infection may be sick with temperatures over 106° F. but they invariably do well and are very soon up and around.

Bacillary dysentery is the next most commonly seen. It's seldom very severe as we see it and is

continued on page 219

Triumphs in Triage*



*MEDICAL triage in war—front-line classification of casualties—is among the toughest assignments of the military physician. Instant diagnosis—often under direct fire—countless variations—new, baffling situations.

Seldom cited, rarely in print, the military doctor has little leisure time. When he does get around to relaxing, you're apt to find him taking his ease with a cheering cigarette.

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† With men in the Army, Navy, Marine Corps, and Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)



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New reprint available on cigarette research — Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York 17, N. Y.

pretty well cleared up in 10 days or so. In the most severe cases we've used various sulfonamides with good results.

There has been quite a bit of amoebic dysentery. In this climate there's little trouble keeping the microscope stage warm; and the amoeba will stay active and mobile for as long as a couple of hours. Treatment with emetine and carbarsone has been almost uniformly effective.

Recently we've had a number of patients with beri-beri heart disease. They've had dyspnea, edema and numbness of their legs. On examination their hearts are large with various murmurs and usually with a gallop rhythm. Their response to vitamin B is prompt and gratifying and it is a pleasure to encounter so many cases of curable heart disease. Incidentally, there is a fair incidence of typical rheumatic heart disease. However, so far I haven't seen a single typical case of rheumatoid arthritis and I believe the laboratory has found sugar in the urine only once!

There's been a wide variety of other conditions in small numbers—such as luetic gummas of bone, tuberculosis, typhoid, khla-azar, Hodgkin's disease, one case of lung flukes, and numerous instances of worm infestations of various types and degrees.

The surgeons have kept occupied with many things. First of all there are the usual number of hernias, appendices, fistulae, hemorrhoids, and traumatic injuries. They have had five cases of ruptured spleens from trauma to spleens enlarged by malaria, etc. Another of their interesting problems has been a rather large group of necrotic ulcers on the lower extremities — the so-called "tropical" or "Naga" sores. Maj. Beardsley has been quite interested in them and has obtained good results by skin grafting them after they've been curetted out and thoroughly cleaned up.

One of the problems the surgeons have is to keep the patients in bed after surgery—in fact they usually don't suceed and in a couple of days after most any type of operation the patients can be seen stumping around the hospital area, apparently with no ill effects.

All in all we're having an interesting and profitable time with not too many discomforts. Everyone is anxious, of course, to get back home at the first opportunity but who can say when that'll be. How long we'll be here and where'll we go thereafter are subjects for speculation.

Perhaps I can find time to send you another installment about the unit after a few more months have brought us further experiences if you would like it.

MILITARY ROUNDUP

Lieut. Comdr. F. Charles Hanson, MC, USN, who has been stationed at the Newport Naval Hospital since his enlistment nearly three years ago, is a diplomate now of the American Board of Ophthalmology, having qualified on the basis of successful examination in June. . . . After seven months of training at the Naval center at Bethesda, Lieut. Comdr. Jarvis D. Case, MC, was placed in charge of the department of epidemiology at the Pensacola Air Base, and more recently transferred to the Charleston, S. C., Navy Yard to set up the epidemiology program there. . . . The last report we had of Lieut. Jack Savran, MC, was that he was engaged in medical work at a war prisoners' camp. . . . Lieut. (s) Edward Ruhmann, MC, USNR, has been in the midst of the Sicilian campaign. . . . Lieut. John R. Cranor, MC, has completed a course in aviation medicine at Pensacola and is now serving with the Pacific air wing. . . . Lieut. Comdr. James H. Cox, MC, USNR, returned to Newport after service in the Aleutians, became the father of a son during the past month.

From England comes word of Lieut. Reginald H. Boucher, MC, who is commanding officer of a hospital unit which has been engaged in evacuating sick and wounded. . . . Lieut. Maurice N. Kay, MC, has been assigned to Camp Blanding after a period of indoctrination at Carlisle Barracks. . . . Lieut. Raymond E. Stevens, MC, USNR, is now on the West Coast, attached to the Naval Air Cadet Selection Board at San Francisco.

CONTROL OF THE COMMON COLD

continued from page 214

Management and to inform them of the above situation and to caution them against entering into whole hearted support of purely financial schemers for the enrichment of pharmaceutical supply houses. When regularly established scientific Medicine has found a cure or a remedy that stands the test of time and will do the work demanded of it, it will be recommended through the usual channels.

Industrialists should realize that the salesman from the medical supply house has something to sell, while the physician and the nurse in the plant have the interest of the employees at heart and the welfare of the organization they serve, and that if they do not feel it advisable to institute cold preventive measures then their opinion should have the greater weight.

FACTS DOCTORS SHOULD HAVE ON

THE ACTIONS OF WINE



Published by the Wine Advisory Board

AN entire generation of physicians lost touch with the medical lore of wine in the United States following the first World War. Actually, however, few other substances have been as widely recommended. This monograph, which summarizes the pertinent scientific literature in the interest that fact be separated from folklore by the application of impartial analysis, will prove of interest and value to specialists in many fields, and to the general practitioner as well.

A section on wine as a food is included. The actions of wine on the gastro-intestinal system, the cardio-vascular system, the genito-urinary system, the nervous system and the muscles, and the respiratory system are discussed. The uses of wine in diabetes mellitus, in acute infectious diseases and in treatment of the aged and convalescent are dealt with. There is a section on the value of wine as a vehicle for medication. Also an important section on the contraindications to the use of wine. Those who wish to pursue the subject further will find an extensive bibliography.

This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

Members of the medical profession are invited to write for this monograph. Requests should be made to the Wine Advisory Board. 85 Second Street, San Francisco.



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FROM THE SECRETARY'S DESK

WILLIAM P. BUFFUM, M.D.

122 Waterman Street Providence

DR. M. H. SULLIVAN HONORED

On Sunday, August 22, in the Muenchinger-King hotel in Newport, once the home and office of Dr. David King, pioneer Rhode Island doctor and sixth President of the State Medical Society, the Newport County Medical Society honored Dr. Michael H. Sullivan, newly-elected President of the Rhode Island Medical Society at an informal dinner attended by doctors and civic leaders from the Newport area.

Characterized by Superior Court Judge Mortimer A. Sullivan as "the most beloved and esteemed citizen of Newport," felicitated by Cornelius C. Moore, president of the City Council, for "his lifetime of service in protecting the health of the citizens of the City-by-the-Sea", and recognized by the State Medical Society through Dr. Elihu S. Wing, president-elect, as "an outstanding leader for the medical profession during these trying times," Doctor Sullivan was presented an attractive electric clock by his colleagues. The presentation was made by Dr. Samuel Adelson, while Dr. Norman M. MacLeod, former President of the State Medical Society, presided as toastmaster, introducing, among others, Comdr. Phineas Bernstein, MC, USN, who brought greetings from the staff of the Naval Hospital, and William R. Harvey, who was spokesman for the board of trustees of Newport hospital.

WAGNER ACT DISCUSSED

On September 22 a meeting of representatives of the state medical societies of New England was held at Boston to discuss the Wagner-Murray-Dingell social security act now before Congress. Representing Rhode Island were Emery M. Porter, M.D., president of the Providence Medical Association and a member of the Legislative Committee of the Society, Herman C. Pitts, M.D., chairman of the Society's committee on Medical Economics and also a member of the Legislative Committee, and John E. Farrell, executive secretary.

PARKING ADJACENT TO LIBRARY

Doctors having occasion to visit the Library during day hours will now find it possible to park their auto on Francis street as a new traffic ruling has changed the parking on both sides of the street from all day to a two hour period.

PAWTUCKET MEDICAL MEETING

The September meeting of the Pawtucket Medical Association was featured by a talk by Halsey DeWolf, M.D., on the work of the Procurement and Assignment Agency in this state. The talk was followed by a question and answer period relative to the military enlistment program for the remainder of this year for physicians.

RESIGNATION

The Council has accepted the resignation from membership of Dr. Charles P. Fitzpatrick, former superintendent of the State Hospital for Mental Diseases. Dr. Fitzpatrick is now affiliated with Dr. Glen E. Myers in the administration of a private hospital at Compton, California.

COMING MEETINGS

Fri. OCTOBER 8—Providence Council of Social Agencies. 3 p.m., at R. I. College of Education.

Mon. OCTOBER 11-*Thurs.* OCTOBER 14—American Public Health Association at New York City.

Wed. OCTOBER 13—Washington County Medical Society. Regular meeting.

Thurs. OCTOBER 14—Kent County Medical Society. Regular Meeting.

Thurs. OCTOBER 21—Pawtucket Medical Association. Regular meeting at Memorial Hospital at 12 noon.

Mon. NOVEMBER 1—Providence Medical Association. Regular meeting at the Medical Library at 8:30 p.m.

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MEDICAL LIBRARY NOTES

COMMITTEE ON THE LIBRARY:
Herbert G. Partridge, M.D.; Samuel Adelson, M.D.; Adolph W. Eckstein, M.D.

THE Librarian of the Rhode Island Medical Society Library announces the recent addition of the following books:—

GASTROENTEROLOGY

Henry L. Bockus—Gastro-enterology. Vol. I—The Esophagus and Stomach. Phil., 1943.

LIBRARY PRACTICE

Janet Doe, Editor—A Handbook of Medical Library Practice. Compiled by a Committee of the Medical Library Association. Chic., 1943.

POLIOMYELITIS

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis. Vol. III, 1942. N. Y., 1943.

SYPHILIS

James K. Howles—A Synopsis of Clinical Syphilis. St. L., 1943.

SPECIAL GIFTS

The Committee on the Library reports with appreciation the receipt of the following gifts to the Library:

4 volumes from Robert S. Phillips, M.D.

Unbound journals from Francesco Ronchese, M.D.

Unbound journals from Edwin Vieira, M.D.

Book Reviews

SYNOPSIS OF CLINICAL SYPHILIS, by J. K. Howles, M.D., Professor of Dermatology and Syphilology, Louisiana State Univ. School of Medicine. The C. V. Mosby Company, Publishers.

The author of this book has concisely arranged the subject of syphilis in a form which lends itself to quick reference for the general practitioner. He discusses the disease first by stages, clinical and laboratory diagnosis, therapy, and prognosis. He then presents a brief but complete synopsis of its various lesions in each of the systems of the body. Finally he considers the epidemiology, the disease in pregnancy, the congenital form, and the organization of a clinic for syphilis.

The text is supplemented by numerous photographs which are always helpful, but unfortunately only two plates are in color. A voluminous list of references at the end of the book offers ample opportunity for anyone who is interested in further information or any particular aspect of the disease. The index is well arranged for the purpose of facilitating handy reference.

Detailed plans of treatment are presented for the various stages and lesions of syphilis. While it is impossible to consider controversial topics in such a small volume, the treatment schedules offered contain rest periods and mercurial rubs, both of which are not conducive to maintaining adequate contact with the patient, at least in this part of the country. The author does, however, offer explicit instructions in the art of handling syphilitic patients and of forming an anti-luetic clinic, which are valuable adjuncts to the therapy of this disease.

D. W. J. BELL, M.D.

GASTRO-ENTEROLOGY (In Three Volumes) —VOLUME I—THE ESOPHAGUS AND STOMACH—examination of the patient and diagnosis and treatment of disorders of the esophagus and stomach, including duodenal ulcer —by Henry L. Bockus, M.D., Professor of Gastro-enterology, University of Pennsylvania Graduate School of Medicine—W. B. Saunders Co., 1943.

From the home of gastro-enterology, the University of Pennsylvania Clinic, comes the first of this new series of volumes on the gastro-intestinal tract. It deals with the esophagus and stomach only and is written by the Dean of American internists in this field—Henry L. Bockus.

The author's approach to his subject is at once simple, direct and complete, as well as authoritative. A preliminary section of the book is devoted to special pointers in history taking, the various special symptoms related to the gastro-intestinal viscera, special pointers in the technique of physical examination with respect to this system, and a short evaluation of laboratory diagnostic procedures.

The subject is then discussed on an anatomic basis considering congenital and anatomic aberra-

tions, physiologic disorders, diseases arising from external violence, infections, and neoplasms of the esophagus and stomach. Each individual topic is discussed with respect to etiology, diagnosis, pathology, therapy, complications, and prognosis, and an exhaustive biblography is included.

Such magnificent organization by this authority cannot fail to answer specifically any question in the field which may arise in the mind of the general practitioner or internist. In particular the section on peptic ulcer, which constitutes more than 300 pages of the volume, is outstanding. The discussion of the various syndromes following surgery of ulcer has nowhere before been gathered together with such finesse. Surgery, the use of the gastroscope, and diagnostic X-ray procedures, of course can never be learned completely from reading, as facility must be obtained by practice, but the theory behind these methods is adequately covered, and plentiful, plain, and colored illustrations are included for assistance in their exposition.

The complete set of three volumes will probably find its greatest use as a reference work because of its length and exhaustive nature. Any section, however, can be read with pleasure and profit as a monograph in itself.

HAROLD S. BARRETT, M.D.

1021 ANSWERS TO INDUSTRIAL HEALTH AND SAFETY PROBLEMS. Published by Occupational Hazards Magazine, Cleveland, Ohio.

An increasing number of physicians are doing industrial accident work. To many of them the operations of the plant are new, complex and strange. When their opinion is asked regarding certain health and industrial hazards, they are often at a loss because their training does not give them a complete industrial education except as to poisonous substances and diseases resulting from toxic products.

This book of six hundred and two pages, amply illustrated with photographs and diagrams, should enable the industrial physician to answer any questions that the Management of plants would care to ask regarding industrial health hazards and methods of their control. It gives extensive references for further reading.

Part of the contents follows: Industrial skin diseases — Dust Hazards — Metal Poisons — Toxic Gasses and Vapors — Solvents — Controls For Air Bourne Industrial Diseases — Hazards — Safety Administration — Personal Protective Equipment — Mechanical Safety — Tool Protection and Plant Safety.

CHARLES L. FARRELL, M.D.

A. M. A. COUNCIL ON PHARMACY AND CHEMISTRY REPORTS 1942. American Medical Association, 535 North Dearborn St., Chicago, Ill.

This volume is an annual reprint of reports "pertaining to the value of certain propriety drugs and compounds presented to the council for acceptance in the New and Non-official Remedies." Many drugs have been much discussed in regards to their therapeutic value. One of particular interest is "use of Bulk Ether in Anesthesia" by Harry Gold, M.D. Because of the shortage of metal due to the war, this article is of more importance than previously, and it does seem that it should clarify some of the doubts of the anesthetists, concerning the use of this container.

Another very enlightening report is "The Present Status of the Higher Types of Antipneumococcus Serums", by Maxwell Finland, M.D.

THOMAS E. MURPHY, PH.G.

continued on page 226

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CIVILIAN DEFENSE

JOSEPH C. O'CONNELL, M.D.
State Director, Medical Aid Division, State Council of Defense

BLOOD PLASMA

To supplement the supply of blood plasma available in the State for use in treatment of casualties resulting from enemy action, the U. S. Public Health Service has loaned 150 units of dried plasma which has been distributed to 11 towns and cities as follows: Newport, 20 units; North Kingstown, Narragansett, South Kingstown, Warren, Tiverton, and Little Compton, 15 units each; Warwick, East Greenwich, Bristol and Woonsocket, 10 units each. Already available at the State Defense Headquarters are 200 units in storage, while Westerly has previously been allotted 100 units.

Rhode Island Hospital, a grantee hospital under the federal plan, has processed and loaned frozen plasma to several of the hospitals of the State. A recent survey showed a total of approximately 1050 units of frozen plasma stored at Rhode Island, St. Joseph's, Homeopathic, Memorial, and Woonsocket hospitals.

The great value of this program was demonstrated anew in the recent train wrecks. In the Wayland (N. Y.) disaster, plasma in a reserve developed for civilian defense needs by the Mt. Morris Sanatarium, 20 miles from the scene of the accident, was first drawn upon, and later 20 units of dried plasma was flown by a Civil Air Patrol plane from Rochester. As the result of this action on the part of OCD Emergency Medical Service the lives of many persons were saved.

NURSES' AIDES

Nurses' aides enrolled in the Nurses' Aide Unit of the Citizens Defense Corps are eligible for the benefits provided under the War Civilian Security program of the Federal Security Agency. Incidentally, a new arm insigne for outdoor dress, as distinguished from the uniform emblem, has recently been designed for members of the Nurses' Aide Unit.

PREPARED FOR DEFENSE

About 12,763 local civilian defense councils have been organized throughout the nation, according to the Office of Civilian Defense. This number includes county and municipal councils. Serving approximately 81% of the total civilian population of the United States the various councils are manned by about 10,743,000 civilian volunteer workers.

NURSE TRAINING

The enactment by Congress of the Bolton Act providing for grants-in-aid to nursing schools whereby the student nurse is granted full tuition and maintenance, including uniform, plus a regular monthly stipend, is expected to go a long way towards solving a possible shortage of nurses both for military and civilian service in the next two years. Stipends given student nurses will amount to $15 per month during the first nine months of training, $20 during the next fifteen to twenty-one months, and $30 or more for the six to twelve months remaining before graduation. The prospective nurse cadet has free choice of school, and following graduation she agrees to continue in essential nursing for the duration of the war.

NEW APPOINTMENT

Within the past month Mrs. Catherine D. Tracy has assumed the post of State Nurse Deputy of the Emergency Medical Division as well as of the Health and Medical Division of Civilian War Services, filling the vacancy caused by the resignation of Miss Winifred L. Fitzpatrick.

NUTRITION

With the food supply representing perhaps the greatest single potential weapon of war in our fight against the Axis, a national food information program will get under way this month and will peak in November, which will be officially designated as "Food for Freedom Month."

BOOK REVIEWS

continued from page 224

THE MIND OF THE INJURED MAN—By Joseph L. Fetterman, M.A., M.D., Assistant Clinical Professor of Nervous Diseases, Western Reserve University School of Medicine. Published by the Industrial Medicine Book Company, Chicago, Illinois.

This book of two hundred thirty-eight pages is a timely addition to our Medical Library inasmuch as it discusses completely and in the simplest of terms the mind of the injured man—not only regarding the actual trauma to the skull and brain,—but as regards the neuroses associated with other physical trauma.

This book first discusses trauma as a cause of nervous illness and then goes on to describe the functional anatomy of the central nervous system —the functions of the brain with physiological consideration — neurological tests — brain damage from trauma—brain contusions and lacerations—and post concussion states.

It deals fairly completely with psychoses—mental disease from brain damage—and psychoses attributed to injury. It also includes a discussion of syphilis with its symptoms in brain disease, as well as the relation of brain tumors to trauma. Traumatic lesions of the spine and the spinal cord are given minute attention with several excellent diagrams. Following this chapter there is one on injuries to peripheral nerves, illustrated throughout with many case histories. Quite a good deal of space is given to neuroses with a discussion of those referable to the digestive system and to the muscular system.

This book also gives for the first time a real technique for case history and examination to detect malingering. To every individual interested in traumatic surgery, industrial health, and compensation insurance work, this book should be invaluable. The social significance of neuroses is also covered and the neuroses associated with trauma form part of the more interesting sections of the book. Treatment is not neglected and is brief, precise, and to the point. This book should furnish physicians with a clearer conception of the physiological changes taking place in the brain following head injury as well as the functional disorders following trauma.

Charles L. Farrell, M.D.

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Rhode Island MEDICAL JOURNAL

NOVEMBER 1943

Volume XXVI, No. 11

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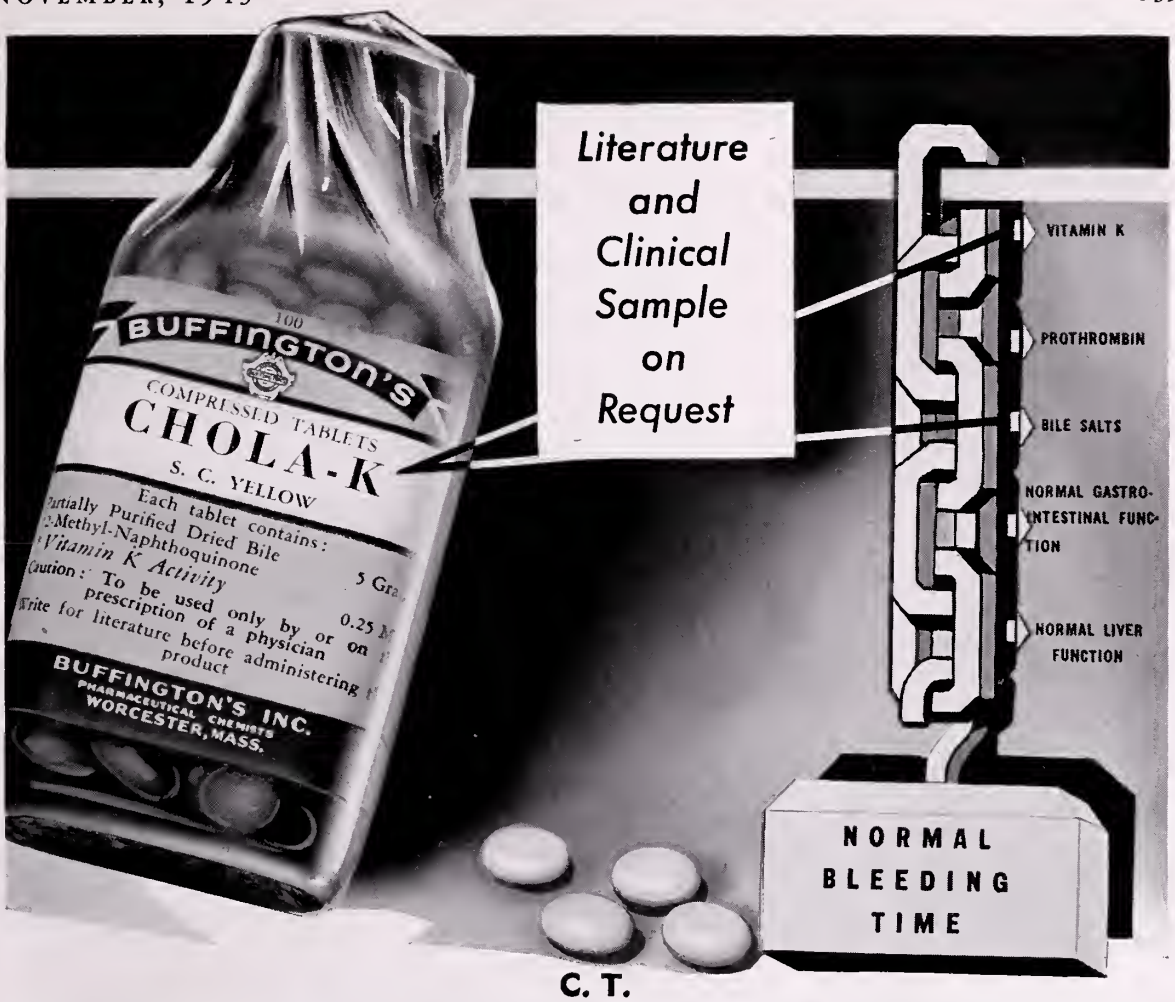
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The RHODE ISLAND MEDICAL JOURNAL

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THE Rh FACTOR—ITS ROLE IN ERYTHROBLASTOSIS-FETALIS, AND INTRA-GROUP TRANSFUSION REACTIONS*

EDWARD S. BRACKETT, M.D. and B. EARLE CLARKE, M.D.

The Authors. *Dr. Brackett, former Chief of Staff, Lying-In Hospital; Dr. Clarke, Pathologist, Rhode Island Hospital*

IN 1940 Landsteiner and Wiener[1] observed that after rabbits were injected with the red blood cells of rhesus monkeys an antibody developed in the serum of the injected rabbits that agglutinated rhesus red cells. This antigenic substance present in the red cells of these monkeys they designated as the Rh factor. They then found that by means of this new immune serum all human bloods could be divided into two sorts, one (85 percent) containing this Rh factor and therefore called Rh positive and the other (15 per cent) lacking it and therefore called Rh negative.

This Rh factor when present is a property of the red cells only, in contrast to the A & B factors of the common blood groups which are present in all the tissue cells and in the blood serum and other body fluids. The anti Rh agglutinin is an acquired antibody in contrast to the anti A and anti B agglutinins which are naturally or normally present.

There are two practical applications[2] of this new knowledge concerning the Rh factor: (1) It explains certain heretofore puzzling intragroup hemolytic transfusion reactions and provides a means of preventing them and (2) It furnishes an adequate explanation as to the etiology and pathogenesis of erythroblastosis of the new born.

Since the discovery of the iso agglutinins in blood and the subsequent use of donors of the same group as the recipient, transfusion reactions have been reduced to a minimum. However, occasional severe and even fatal transfusion reactions have occurred following the use of blood from donors of the same group as the patient. A series of these intragroup reactions were reported and explained by Wiener and Peters[3] in 1940 as due to isoimmunization of Rh negative patients by transfusion with Rh positive cells.

The way in which this is brought about is explained thus[2]—the transfused Rh positive erythrocytes are antigenically active and stimulate the production of anti-Rh antibodies in the blood of the Rh negative recipient. There is no reaction to the first transfusion because as yet there are no antibodies present. However, a second, third, or some subsequent transfusion may result in a severe reaction. In other words an interval of time must elapse sufficient to permit the development of the anti Rh antibodies in the patient's blood. This interval of time is variable.

Such reactions do not occur often because multiple transfusions are not frequent, a certain portion of such incompatibilities are eliminated by the usual methods of cross matching, most individuals (85 per cent) are Rh positive and there is marked variation in the ability of Rh negative individuals to develop the antibodies. (*Charts 1 and 2*)

It has frequently been noted that such intragroup transfusion reactions occur much more frequently in pregnant women. Most important is the fact that in this group the accident occurs as a result of the *first* transfusion. Analysis of the histories of these women revealed a high incidence of spontaneous abortions, miscarriage, still births and neonatal deaths.[4] Thus there seemed to be some relationship between these obstetrical mishaps and the transfusion reactions. This relationship was explained when it was found that certain of these women had had one or more babies with the familial disease, Erythroblastosis fetalis, which is characterized by a hemoyltic process initiated in utero. We shall come back to that shortly.

Since these intragroup hemolytic transfusion reactions in pregnant women occur following the first transfusion, it is clear that something must have occurred during and resulting from the pregnancy that made them susceptible. Levine[5] studied sixteen pregnant women who had had such trans-

*Presented at the meeting of the Providence Medical Association, October 4, 1943.

fusion reactions, five of which were fatal. All of these women were Rh negative and their husbands were Rh positive. In pregnancy it is assumed that the father who is Rh positive transmits this factor to the fetus. From the fetus Rh positive red blood cells escape into the blood of the mother and stimulate her to produce the immune agglutinins. In this way she is conditioned for a hemolytic reaction following a transfusion with Rh positive blood (frequently from the husband). (*Chart 3*)

Erythroblastosis fetalis exhibits some of the following characteristics in the fetus: A profound, usually fatal anemia, caused by the destruction of red cells. Hyperactivity of the blood forming organs in an effort to replace the destroyed red cells. This hyperactivity results in the appearance in the blood stream of many immature nucleated red cells (normoblasts). Enlargement of the liver and spleen. Enlargement of the placenta which may be two or three times its normal size. Prenatal jaundice with a greenish staining of the amniotic fluid, placenta, cord and membranes. Pronounced edema of the fetus including the placenta. The repeated occurrence of the disease in the offspring in all or several pregnancies of a particular mother. A high incidence of abortions, miscarriages, premature labors and stillbirths in mothers who have given birth to erythroblastotic babies.

All of the foregoing characteristics have been known for several years. An investigation of the Rh factor has established still another characteristic: In over 90 per cent of cases of erythroblastosis the mother is Rh negative and the father and baby are Rh positive. Levine[5] and his co-workers studied the blood of one hundred and eleven mothers who had had babies in whom a diagnosis of erythroblastosis fetalis was established. Of these, 101, or 91 per cent, were Rh negative and only 9 Rh positive.

Burnham[6] explains the pathogenesis of erythroblastosis as follows: "There is present in the fetal red blood cells an antigen inherited from the father which is lacking in the mother. This antigen diffuses from the child into the mother's circulation, stimulating the formation of destructive antibodies. These antibodies, like other maternal antibodies (for example diphtheria antitoxin) also diffuse readily into the fetal circulation, where they can attack the red cells which contain the antigen, thereby causing erythroblastosis." (*Chart 4*)

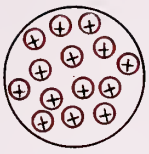
Fetuses that survive 9 months of exposure to this antibody in utero and are born alive are likely to show erythroblastosis fetalis in some of its various forms such as hydrops neonatorum, icterus gravis, or congenital anemia. Many do not survive this long and are born dead prematurely. Future investigations of still births will probably show that many are Rh positive and their mothers Rh negative.

From the figures given at the beginning of this paper it has been calculated that in 12 per cent of all matings the husband is Rh positive and the wife Rh negative. Yet statistics also show that only one out of every 438 babies suffer from erythroblastosis. There are probably several reasons for this low incidence. It seems probable that in many cases the placental barrier between the fetal and maternal circulations may be so efficient as to prevent the passage of the antigenic Rh substance from the fetus into the mother. All Rh negative mothers may not be capable of producing the anti-Rh antibodies. In the production of the antibodies in rabbits by inoculation with monkey red blood cells it is found that only one rabbit out of ten will produce a potent agglutinin. It is quite probable that there is a similar variation in Rh negative women. One or two previous pregnancies seem to be necessary to cause sufficient antagonistic substances in the mother's blood to affect the baby, so that first born babies are not likely to be erythroblastotic. The present tendency toward small families therefore lessens the incidence. Since many of these pregnancies result in abortion and miscarriage the condition is not always diagnosed. A certain number of Rh positive fathers are hetero-zygous and therefore may not transmit the Rh factor to the fetus. The Rh factor has been shown to be inherited as a Mendelian dominant.[7]

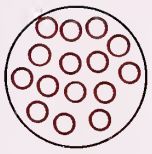
From a study of the role of the Rh factor in the causation of erythroblastosis and intragroup reactions following repeated transfusions the following observations are of practical significance. There is one chance in seven that a given patient is Rh negative. Patients having reactions against blood in their own blood group are usually Rh negative patients who have had one previous transfusion with Rh positive blood or if the reaction takes place with the first transfusion are mothers of babies suffering from erythroblastosis of greater or less severity. A patient likely to require repeated transfusions should be tested for the Rh factor and if found to be Rh negative should be transfused with Rh negative blood only. An Rh negative patient who has had a reaction from Rh positive blood can be safely transfused with Rh negative blood.

continued on page 244

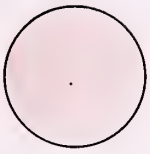
SYMBOLS



Rh+ 85%



Rh— 15%



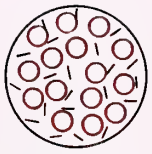
Hoemolysis

CHART I



(Rh—) + (Rh+)

Formotion by Rh— blaad af substances ontoganistic to Rh+ blaad



Rh— ofter Rh+ Tronsfusion

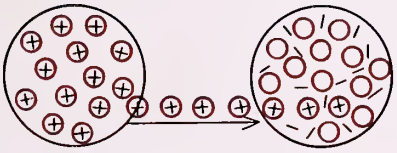
Antaganistic substance persistent in Rh— blaad for weeks or longer after first transfusion with Rh+ blood

CHART II

Mechanism af Rh Foctor in Praducing Tronsfusian Reactians in Men, and in Wamen who have never been pregnont

Blood of First Rh+ Donor

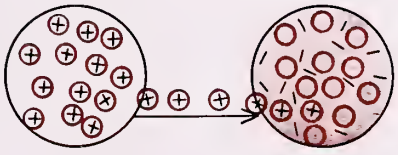
Blood of Rh— Recipient



Formotian of substonces antogonistic to Rh Positive Blaad

Subsequent Rh+ Donor

Rh— blood now Antogonistic to Rh+ Blood



Agglutinatian Haemolysis Transfusion Reaction

CHART III

Mechonism of Tronsfusion Reactian in Mother of Erythrablastic Faetus

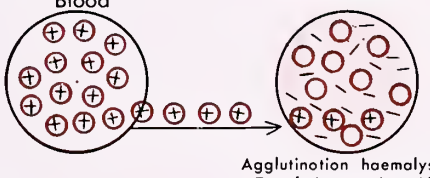
Blood of Mother (always Rh—) recently delivered af, ar carrying, on Erythroblastic Faetus

Contains substance antaganistic ta Rh+ Blood



Rh+ Husbond's or other Rh+ Donor's Blood

Rh—Mother



Agglutinotion haemalysis. Tronsfusion reactian with fusion reoction with first tronsfusion

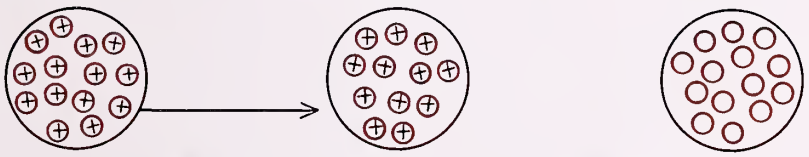
Note: Women who have had stillbirths of unknown cause, repeated miscorrioge or eclompsio show o high incidence of Rh— findings

CHART IV Mechanism of Rh Factor in Production of Erythroblastosis

Fother Rh+

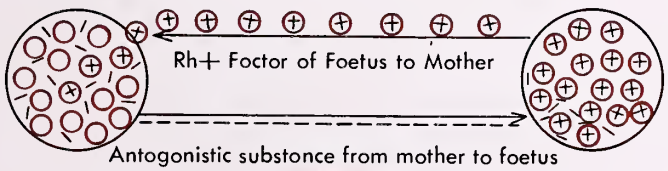
Foetus Rh+

Mother Rh—



Fother ond Foetus must both be Rh+; mother Rh—

Mother Rh—



Rh+ Foctor of Foetus to Mother

Foetus Rh+

Antogonistic substonce from mother to foetus

End Reoction in Rh+ Blood of Foetus



Destruction af faetal red blaad cells, haemolysis ond compensatory formation of normoblasts

A mother of an erythroblastotic fetus is always Rh negative and has, in effect, had a transfusion of Rh positive blood from the fetus. She may therefore have a reaction with the first transfusion with Rh positive blood and should be transfused only with Rh negative blood.

There is an abnormally high incidence of repeated abortion, miscarriages, premature labor and stillbirths among women known to be Rh negative. Patients giving such a history should be suspects and should not be transfused without their blood being tested for Rh factor.

The Rh factor is present in the red cells and not in the serum. In cases of such urgency that it is impracticable to employ the time consuming Rh test, plasma and not whole blood should be used for emergency transfusion. Every gynecological service and especially every obstetrical service should have a list of Rh negative donors.

The Rh positive blood of a newborn erythroblastotic infant continues for some time after birth to destroy Rh positive blood cells. Therefore Rh negative blood should be used in transfusing known or suspected cases but the Rh negative blood of the mother should not be used as it may contain substances inimical to the blood of the newborn.

Tests for the Rh factor may aid in the diagnosis of erythroblastosis in anemias of the newborn in which the disease is not of sufficient severity to cause the typical blood picture and the classical signs.

Anti Rh substances have been demonstrated in the blood of the mothers of erythroblastotic infants for periods up to three years post partum. Cases are on record in which there was a blood transfusion reaction some years after a previous transfusion. Therefore, any patient, man or woman, who has had a previous transfusion should be tested for the Rh factor and if Rh negative should be transfused with Rh negative blood and any woman who gives a history of having had an erythroblastotic infant, repeated abortions, miscarriages, premature labors, stillbirths or neonatal deaths should be suspected of being Rh negative and transfused with blood from Rh negative donors.

If the above precautions are observed the incidence of intra-group hemolytic transfusion reactions should be reduced by 90 per cent. There still remain 10 per cent that are unexplained.

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THE WAGNER-MURRAY-DINGELL ACT

A Preliminary Report by the Committee on Public Laws of the Rhode Island Medical Society on the Social Security Amendment Now Before Congress

THERE have been many fine analyses and reports, notably the one prepared by the Bureau of Legal Medicine of the American Medical Association, on the Wagner-Murray-Dingwell Act now before Congress. Merely to reiterate in this report the provisions of the act and the excellent observations already made by authorities would appear to avail little. Therefore this Committee has concerned itself in this preliminary report with what it believes to be the basic purpose of the proposed legislation, and has endeavored to determine whether this purpose can be achieved in a manner that will result in better health for the people of this country, and more particularly the people of the State of Rhode Island.

Disposing, therefore, without discussion, of the apparent faulty mechanism of the proposed act which would make the Surgeon General of the United States the supreme head of all medical and health services, even to the extent of controlling the general practice of medicine, this Committee recognizes the following as the objective sought by the Title IX of the Wagner Act (which incidentally is the only part of the legislation considered in this preliminary study):

The development by means of the insurance principle of a program nationwide in scope whereby medical and hospital care may be budgeted so that each family carries a budgeted rather than, as at present, a variable risk, thus assuring that everyone will have the money to pay for medical and hospital care, and as a corollary to this theory, that everyone will seek medical attention promptly and good health will thereby be attained to a greater extent than heretofore.

In considering this objective this Committee omits discussion of the vast new bureaucracy which would be created by the adoption of a national insurance scheme to include health provisions, and it concerns itself with the primary concern of the medical profession: Will such a program actually give better health care, or for that matter provide the best return to the public for the public funds expended? As a strictly insurance program whereby moneys will be distributed on a nationwide basis to all individuals equally there is probably little question that this phase of the plan is workable, but that the better distribution of funds will result in better medical or hospital care is not proved by any authority advocating passage of the Act with Title IX included.

We think that medical and hospital care for the public would not be improved by this program. There is little need in this report to cite what is only too well-known—the facts relative to the good health enjoyed by the people of this country as compared with the peoples of other nations. That there is a segment of our population, however, that may not be receiving all the benefits of modern medicine and hospitalization may be admitted, but that the remedy for this shortcoming is a national insurance scheme which would lower the standards of all to raise the standards of a few is certainly not reasonable.

Title IX at best is merely a device to allow Social Security to pay bills, thus providing minor alleviation of a financial need at the time of a present illness. It does not provide better health care in any manner, and in fact fails throughout its provisions as listed to advocate what would certainly be the best form of health social security—preventive medicine. On the contrary it proposes devices that would discourage prompt medical care when it stipulates that "the Surgeon General and the Social Security Board may determine that every individual entitled to general medical benefit may be required to pay a fee with respect to the first service or with respect to each service in a spell of sickness or course of treatment." This device to preserve the financial status of the Social Security funds finds no counterpart in present medical care where the medical profession places itself every day in the year at the disposal of the sick, regardless of the ability to pay a fee for service rendered.

Again, consider the ruling relative to hospitalization (SEC. 908) whereby hospitalization is denied the mental or tubercular patient, and SEC. 902 whereby the hospital stay in any instance is limited to 30 days. Yet the Blue Cross voluntary hospitalization program in Rhode Island today offers its members a minimum of 21 hospital days, and it will recognize also first admission for tubercular or psychiatric conditions.

Consider the provision of the act (Sec. 905 (2)) whereby specialist services would be available only on consent of the general practitioner, and realize that this provision gives the incompetent doctor and the doctor who does not keep abreast of the latest scientific advances a control over his patients to the extent that they could and would be denied the services of a trained specialist.

Can these phases of the program be construed as advances towards a better health for the people of our state and country?

Not only would the regulations of the act (to say nothing of what further restrictions might be imposed once an administrative force was authorized to supervise a nationwide program) result in a deterioration of medical care, but they would further discourage early diagnosis. The theory advanced that everyone would seek medical care if it were available at a low cost is fallacious, as has been proved by the experience of the Life Extension Examiners which, in serving the policyholders of 39 different life insurance companies, has examined approximately three million people during the past 25 years. These examinaations, given to policyholders at no cost to them, and the report in no way affecting existing contracts, offer an answer to whether the average person demands the preservation of good health while he still has it. The result of this free offer of periodic health examination is reported by Dr. Harry J. Johnson, director of Life Extension, as follows:

> "It has been our experience that only 5% of those entitled to the services avail themselves of the privilege. From our studies 80% of those who take advantage (i. e. of the 5%) of the service come in the smaller policy group, that is, those with less than $2,000 of life insurance, which would certainly indicate that the greatest interest in the service is found in those people in the lower income bracket."

Medical care is a service, not a commodity that can be purchased over the counter. Therefore, the mere distribution of funds to meet costs is not sufficient basis for the introduction of a national scheme which would disrupt all the advances made and being made on a voluntary basis. That certain parts of the country merit additional national support to bring them abreast to the more advanced sections is not disputed. But free choice as a principle should not be discarded merely because some sections cannot assure such choice actually.

We would strongly urge that our States seek ways to advance assistance to the people of any State to improve health conditions, provided such financial aid from a national pool is not used as a political gesture. There is much to be done in the improvement of public health in every State, and public funds undoubtedly must and should be utilized in every State to improve the health services for all and to assure the medically indigent of proper care. The greatest contribution that Social Security can make is in the work of preventive medicine. The Surgeon General himself has been reported as stating that if the appropriation for malaria control were doubled the disease could be eliminated in a short time. Likewise there is little doubt that the appropriation of sizable funds to augment those of state and private agencies could provide for research, hospitalization, and medical care which would make vast inroads on the control of tuberculosis, cancer, and equally serious diseases.

Title IX of the Wagner Act cannot, then, be considered as a panacea for the health problems of the nation. The good health of the individual depends on more than the mere possession of cash in the pocket to meet an emergency illness. It requires a well-rounded study of the family, its home environment, its food, its recreation, and its aptitude for accepting sound health education in preventive medicine. Man is master of his destiny, and as long as he chooses to ignore or neglect the sound advice to preserve his good health, then so long will we be faced with the illnesses from neglect and ignorance with the subsequent strains on the individual's economic status.

The Committee makes the further observation in this preliminary report that the controversy relative to the present Wagner Act brings forcibly to the attention of the medical profession once again the alluring picture that partisan groups, political or otherwise, can present to further their objectives. The challenge is there, and it remains for the medical profession throughout the country, and for our own State Medical Society in particular, to initiate a factual study of local facilities for health and medical care and to take the leadership in solving the health and medical problems of all our citizens, giving full thought to the utilization of private, state, and federal programs.

The Committee on Public Laws,

Chairman, William H. Foley, M.D., Lewis B. Porter, M.D., Herman C. Pitts, M.D., Henry E. Utter, M.D., Emery M. Porter, M.D., Earl F. Kelly, M.D.

MATERNAL MORTALITY

COMMITTEE ON MATERNAL MORTALITY

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(With this issue of the JOURNAL *the Committee on Mortality presents a case report and discusses it for the benefit of the membership of the Society. As a form of post graduate medical education this type of presentation should be of great value to every doctor. THE EDITORS.)*

CASE HISTORY

PRIMI-GRAVIDA. Last menstruation June 5, 1940. Four ante-partum visits. First October 16, last January 3, 1941. Blood pressure 100/80, 90/50, 110/70. Urine normal. No gain in weight. Chronic cough for five years. A diagnosis of probable pulmonary tuberculosis was made and confirmed by x-ray. Admitted to State Sanatorium November 7 where repeated sputum examinations were negative for tubercle bacilli. Guinea pig inoculation was also negative. There was loss of weight, tachycardia, questionable exophthalmos, lid-lag, tremor, excessive perspiration and a metabolic rate of plus 37. Thyroid not palpable. She was discharged from the sanatorium as non-tubercular with a diagnosis of hyperthyroidism. Admitted to the hospital for observation and treatment January 3, 1941. Throughout her thirty-nine day stay in the hospital her temperature was normal as were her blood pressure, urine and leucocyte count. Hgb. 57% on January 4 and 72% on January 11. Sputum culture showed a predominance of green colonies probably streptococcus viridans. Blood culture was sterile. Repeated x-ray examinations showed no substernal thyroid, but varying degrees of soft infiltration of the upper lobes of both lungs; no cavity formation; prominence of the pulmonary artery and pulmonary conus; the aortic shadow was quite small suggesting congenital heart disease. Early examination by the cardiologist who made a definite diagnosis of mitral stenosis and regurgitation. There was pronounced tachycardia, orthopnoea and cyanosis. Her condition was serious throughout her stay in the hospital and at times alarming. Ligation of the poles of the thyroid was considered but was rejected because she was "too near term". Five weeks after her admission to the hospital and one month before her due date there was an apparent improvement in her condition which was felt was merely temporary. It was fully realized that she was a very poor surgical risk but as there seemed to be no probability that after five weeks of bed rest there would be any further improvement in her condition it was decided that she should be delivered. As x-ray pelvimetry showed a small gynecoid slightly flat pelvis, a rapid classical Caesarian section was done February 7 under spinal anaesthesia and a live baby weighing five pounds and ten ounces was delivered. Immediately after the extraction of the baby the patient developed cardio-vascular collapse and died within three minutes. No autopsy was permitted.

Cause of death: Hyperthyroidism, mitral stenosis, Caesarian section.

Discussion

In analyzing a fatality of this kind in retrospect it is easy to point out possible errors in management. There was no neglect in this case. The seriousness of the condition was recognized. All aids to diagnosis and prognosis were employed. Medical consultants were called in. If there were any mistakes in management they were errors in judgment.

It is easy to say that this or that should have been done but it is impossible to know whether the outcome would have been different if a different course of treatment had been followed.

However, this case, though the committee does not presume to criticise the way it was treated, does present some points which may be discussed with profit.

When the obstetrician calls in a medical or surgical consultant he should not abdicate his position as the one responsible for the final decision as to the obstetrical management of the case. The experienced obstetrical specialist sees many more com-

plications of pregnancy than any medical or surgical consultant. The physician is inclined to over estimate the strain of pregnancy and labor and under estimate the seriousness of therapeutic abortion. The cardiologist on the consulting staff of an obstetrical hospital is less and less likely to advise abortion in heart disease the longer he is on the staff and the more women with seriously damaged hearts he sees go through pregnancy and labor successfully after he had advised therapeutic abortion in the early months. Some surgeons hesitate to do an operation on a pregnant woman fearing that an abortion may result or, if she is near term that she will go into labor and an abdominal incision will give way. The obstetrician knows that the first stage of labor puts very little strain on the abdominal wall and the obstetrician can, if necessary, eliminate the second stage. If an abortion follows an operation it is more often the condition for which the operation was performed than the operation per se which causes the abortion. In acute abdominal conditions such as appendicitis, a uterine fibroid with a twisted pedical, an ovarian cyst or cholecystitis with impending gangrene, pregnancy makes the indications for immediate surgical intervention doubly urgent. It may be laid down that, as a general rule, the operations of elections may be postponed but that in any condition that demands immediate operation in a non-pregnant woman, pregnancy makes the indications for operation still more urgent.

In a complicated case such as the one here reported, there is a temptation for the obstetrician and equally for the consultant to avoid the responsibility of making the diagnosis which will determine the course of treatment. Should the patient be treated as a case of mitral stenosis or of hyperthyroidism? The committee is in no position to know whether there was divided responsibility in this instance but it is evident no decision was made until the patient was in the opinion of the obstetrician and the consultant "too near term" to justify an operation on the thyroid. The proper course to follow in a similar case would be to call in a competent surgeon and as soon as the diagnosis of hyperthyroidism was made, ask him not "do you advise operation for this woman" but, "if this woman were not pregnant would you advise operation". If the answer is "yes" that surgeon should operate and the obstetrician determine the subsequent obstetrical management.

Was this patient in fact "too near term" to justify an operation? If the operation had been successful and the patient gone to term would her condition in the intervening four weeks have improved? If the operation had been followed by premature labor would her condition have been worse than if she had not been operated?

Was the choice of the anaesthetic wise? In a patient with mitral stenosis and regurgitation and a heart overloaded by pregnancy and the tachycardia of hyperthyroidism would the danger of cardio-vascular collapse following emptying of the uterus been less if the operation had been done under local or general anaesthesia instead of under spinal?

Was Caesarian section the best method of delivery? The best opinion appears to be that Caesarian section puts a greater strain on a damaged heart than the first stage of labor and an operative delivery as soon as the cervix is fully dilated and retracted and the head is well engaged. This patient had a small, slightly flat pelvis. The presumed pelvic disproportion plus the heart condition were in this case the indications for section.

In every large obstetrical clinic the ease with which patients with serious cardiac decompensation are delivered is an ever recurring cause for amazement to the staff. In view of her apparently somewhat improved condition should this patient have been allowed to go to term with the hope that the heart condition would at least not deteriorate and the baby could be delivered without Caesarian section?

These questions are asked not in the belief that catagorical answers can be given but in the hope that they may indicate the complexity of the problem this case presented and suggest some general principles which should be followed in the management of obstetrical cases with medical or surgical complications.

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PATTERN OF STATE MEDICINE

When the Rhode Island Cash Sickness Act was written into the law the hope was expressed that it might set a pattern for the country as a sensible approach to the economic problem faced by the worker as the result of the loss of his wages due to unemployment because of illness. The public was told of the great benefits that would accrue to it as the result of the measure, and the medical profession, faced with the task of certifying illness, gave assurance that it would assist the Unemployment Compensation Board in its efforts to make the plan a success. Unfortunately the Board has never fully utilized the proffered assistance of the State Medical Society, and as a result the administration of the sickness act at the present time is far less satisfactory than would appear on the surface.

The fact that the General Assembly saw fit to contradict to some extent the original purpose of the sickness act, by opening it up to be utilized as an additional benefit to those already receiving workmen's compensation benefits, is no excuse for the Board to attempt to preserve the financial status of the fund at the expense of contributors. Its recent public report stating that more than 3,000 potential beneficiaries have been denied claims would indicate that such a situation exists.

In the first instance, consider the statement that out of about 6,000 persons ordered to appear for examinations before board physicians to support their claims for sickness benefits more than 1400—or nearly one-quarter—failed to put in an appearance. Therefor they were immediately denied further benefits. But why did so many fail to appear? Were they all malingerers? Or isn't it highly possible and probable that the majority of these people resented the idea of being called to a downtown office building at a stipulated time on a set date, there to be given a cursory examination before doctors strange to them who would on the spot decide whether or not the person could go to work?

What of the family physician who made the original diagnosis and who ordered a definite period of convalescence? Doesn't his opinion count after the first few weeks that benefits are paid? How many of the administrators of the program would be willing to submit to the cursory examination given by the Board physicians instead of complete care by the doctor of their choice? Little wonder, then, one-quarter of the persons ordered to report refused to do so, preferring to sacrifice their claims rather than to be treated in such manner. Of course such persons could appeal the action to the courts, provided they could afford counsel, time and the subsequent publicity to prove their claim for a few weeks of benefits.

Then, too, the report states that about 1,650 persons were denied benefits after examination. Why? Every claimant gets benefits solely on the certification of the physician of his own choice. Does the Board, then, imply that the doctors are falsifying the petitions for the claimants? If so, proper redress is available in the act to penalize the doctor. Certainly the claimant should not be denied continuance of benefits that rightly accrue to him as the result of his contributions, if he is unable to work because of illness. And his own physician should be the sole judge of his physical condition for return to work.

The idea of the sickness fund becoming a banking proposition whereby millions are pyramided to protect the solvency of the plan, at the expense of the wage earner who is ill now and needs immediate assistance, is contradictory to the whole idea as originally evolved. And the creation of a paid medical staff subject to the rules of the Board cannot, and must not, be construed as any endorsement whatever by the medical profession of Rhode Island of the procedures now being pursued to deny benefits.

SELECTIVE SERVICE REJECTIONS

No set of statistics has been subjected to more adverse publicity in the past decade than the Selective Service System figures of registrants physically examined and rejected at either local boards or induction centers . The magnitude of the problem became the concern of everyone interested in public health work, as well as those responsible for the administration of the Selective Training and Service Act of 1940.

But the ones who really capitalized on the figures were those groups seeking to prove, rightly or otherwise, that American Medicine had failed in its obligation to the people of the country, and that the health of America was indeed in a precarious condition. The public was alarmed by statements of such groups, and its concern was increased with the realization that these young men were below the age level at which degenerative diseases usually occur, and they had been drawn from useful occupations in civil life which they had followed without apparent handicap.

The assurances by medical and health authorities that the health of the nation was not "disgraceful", and that the rejection rates must be considered from several points of view, and not merely as basic figures indicting the youth of the country, contradicted some of the rash conclusions but they did not repair all the damage done.

The outstanding analysis, therefore, of the causes of rejection and incidence of defects, based on reports of physical examination from 21 selected states from November, 1940 through September 1941, issued by the National Headquarters of the Selective Service System, offers an excellent study of the entire problem. Of particular importance is the interpretation of the rejection rates which were as high as 52.8 per 100 registrants, white and negro combined. The report includes the following significant conclusions:

"However, several pertinent factors have often been neglected in public discussion of these rejection rates.

"(1) A large number of physically fit registrants chose to enlist in the armed forces without awaiting induction through the Selective Service System. If they had entered the armed forces through Selective Service the records would show larger number of inductions, the same number of rejections, and lower rejection rates.

"(2) Failure to meet the relatively strict standards then in force did not necessarily mean that the rejected man was seriously handicapped for a useful role in civil life or for many kinds of noncombatant service in the armed forces. Approximately one-half of the rejected men were classified as available for limited military service. Subsequently, with changes in physical standards, many limited service men were reclassified and inducted.

"(3) During peacetime it was not merely possible but desirable to set higher physical standards than in wartime. At that time the problem was not to raise a large Army; the Selective Training and Service Act provided that no more than 900,000 men should be "in active training or service in the land forces of the United States at any one time." The objective was to select and train the nucleus of an Army composed of men physically fit for any type of service and the standards were set accordingly. As an example of the difference between peacetime and wartime standards, registrants with syphilis and gonorrhea were not accepted for training and service during peacetime, and this elevated the rejection rate, particularly among the Negroes. Later, the standards were changed to permit acceptance of a considerable number of men with uncomplicated cases of syphilis and gonorrhea for treatment after induction. A further consideration that influenced the physical standards was the large

number of claims for service connected disability brought against the Government during and after World War I. In particular, the claims based on mental disorders, popularly but inaccurately termed "shell shock", had been so numerous and so costly that it was considered important to reject men who were likely to break down in service and become lifelong wards of the Government.

"(4) Under peacetime standards the proportion of registrants rejected because of failure to meet literacy standards, for moral reasons, or because they were aliens, was greater than under wartime standards."

When it is further noted that the high rejection rate noted above is for whites and negroes combined, and that the rate for the latter group is exceptionally high due to syphilis and failure to meet literacy standards, then the apparent ill health of our nation is a far cry from what was publicized in exaggerated claims made upon the first announcement of draft refusals. It is to be regretted that the opinions of the National Selective Service System in its recent study have not received wider recognition by the public.

"MAJOR SURGERY AND AMYLOIDOSIS"

The above title is the one given to an article by Dr. J. Murray Beardsley appearing in the August, 1943, issue of the *Journal of Thoracic Surgery*, pages 590 to 600. This article is recommended for reading and careful perúsal by all physicians regardless of the field of medicine or surgery in which they may be interested. It is a splendid article clearly recording Dr. Beardsley's experience with a case of advanced amyloidosis in which he carried out multiple major operations in order to obliterate a focus of infection. He calls attention to the general belief that such procedures are unwarranted in the presence of advanced amyloidosis.

The case report of this patient which covers a period of treatment extending over a period of nine years reveals an example of courage and persistence. In spite of often discouraging circumstances, various stages of the operative procedures were carefully planned and successfully executed. It furthermore serves as an admirable guide to others who may be confronted with the duty of deciding the fate of patients afflicted with amyloidosis and who may be amenable to help by properly directed surgical procedures. The excellent result Dr. Beardsley obtained in his case fully attests the soundness of the view which he expresses in his paper, namely, for a most optimistic attitude in undertaking major surgical procedures in the face of severe amyloidosis.

TOMORROW'S CHILDREN

In order to improve health and control disease it is necessary to solve existing problems and anticipate new needs before these needs become problems themselves. The present health status of our community appears to be well controlled by the responsible agencies. There has been no cause for alarm in the recent spasmodic increase in poliomyelitis; the death rate from pulmonary tuberculosis continues to decline; venereal diseases do not constitute an unsolved problem; our usual seasonal epidemics of measles, whooping cough and chickenpox are no more alarming than before. It is obvious that to improve community health, efforts should be directed to the expectation of needs that will arise during the next few years. In anticipation of future problems, it would seem that strong consideration should be directed to the needs of children.

One of the most startling results of the present conflict is the definite sharp increase in the number of births throughout the United States. Rhode Island has kept pace with this national trend. In 1933 the number of resident live births recorded in the State was 10,341; in 1939 there were 10,368; in 1941, 11,430; in 1942, 14,105. The 1942 figure is approximately 36% more than that of 1939. This is indeed startling. It calls for serious thought about the health and welfare of these children.

To consider the problems that might be presented by a sudden large increase in children we must weigh the ability of the parent and the community to fulfill their respective obligations. The health of the child largely depends upon the social condition of the family which in turn largely depends upon the health of the parent. The parents of many of these births will necessarily comprise members of the armed services. The devastating effect of war will leave its impression on many of the fathers in service. It is inevitable that a number will return unable to dispense satisfactorily their responsibilities over the formative years of the children. Their defects will be manifested as traumatic disabilities, psycho-neurotic states and infectious or parasitic diseases. The major responsibility will then often fall upon the mother.

Here again, we will find a group who themselves, for one reason or another, will be unable to advance their child physically, morally and mentally along the ideal path to proud manhood and womanhood. In some of these instances the community itself will have to assume the entire burden for the care and development of the child. In the greater majority, however, the community will have to assume only part of the responsibility. It behooves us to examine our community facilities and determine if we are now able to help in solving these problems which are justifiably anticipated.

To breakdown anticipated needs of children, we might consider into what groups they themselves will fall. First, there will be children who, as mentioned above, will be thrown entirely upon the community for support. A second group might be those whom the community will have to share in developing. A third group will be those who are afflicted with one of the disabling diseases or deformities and who primarily will need health correction. Another group will be such as need care for certain periods in the year in order to improve their health. And, finally there will be some who should be removed from the home for certain lengths of time during the year, to provide a harassed and hard-working, or an ill mother, an opportunity to obtain for herself an essential vacation, rest or convalescence.

The problems of the first two mentioned groups are well recognized and certainly have been adequately cared for during recent years. We anticipate that the responsible groups will themselves foresee future needs and be prepared to handle the increased problems satisfactorily. The demand for the facilities which are now available for the second group might be taxed when the new births advance in age and become more susceptible to the menace of disabling illness and injury. Obviously we expect an increase of disease proportionate to the increase in children. The last mentioned group, however, may be that which could be given greater consideration than previously. In the more fortunate walks of life it is customary for the parents to take a vacation each year, frequently away from their children. It is obvious that an equal or greater health taxing burden is placed upon the less fortunate parent caring for several children. It is equally important with other problems that we provide opportunities for such mothers to obtain vacations several weeks each year, knowing her children will be placed in suitable environment.

Much of the national post war planning has appeared to devote itself to finances, the rehabilitation of soldiers and the return of industry and labor to peace time production, but little has been said of what we shall do to solve the problems of the vastly increasing number of children.

CORRESPONDENCE

The editorial entitled "Syphilophobia" in the September issue of the RHODE ISLAND MEDICAL JOURNAL called attention to the fact that lues is not as prevalent as we have been led to believe. There was the strongly implied opinion that not only have the dangers of syphilis been overemphasized, but that the campaign to educate the public has been overdone. Evidence was presented to indicate that lues is a problem in the negro rather than the white.

In compliance with the appeal which closed the editorial, "Let's get realistic about syphilis," are the following figures supplied by the Rhode Island Department of Health:

Reported Cases of Syphilis

Year	Total	White	Colored	Unknown
1940	1039	910	128	1
1941	1331	1156	166	9
1942	1327	1133	179	15

These totals do not include cases previously reported. During the decade 1932-1942 13,000 cases of syphilis were reported to the Health Department in Rhode Island. If these patients are treated over a period of years, many years in numerous instances, it is probable that there are at least 5,000 people in Rhode Island receiving antiluetic therapy at all times.

While it is true that the percentage incidence of lues is many times greater in the colored, it is clear that this *preventable* disease is present in this state in nearly 7 times as many whites. If the reverse were true, would the problem be of any less concern?

There is often a latent period in syphilis and many of the victims reported to the Health Department in Rhode Island have not suspected the presence of lues until one of its tragic and quite realistic manifestations, such as irreparable damage in the cardiovascular or central nervous systems, has occurred. The evidence published in the RHODE ISLAND MEDICAL JOURNAL for February, 1941, revealed that in the Syphilis Clinic at the Rhode Island Hospital 11.6% of the patients over 40 years of age suffered from cardiovascular lues. The manifestations of tertiary syphilis which were so prevalent 25 years ago *have* become much less

common: is this not due to the effectiveness of the therapy which has developed during this same period and to the more general use of serologic diagnosis?

It is known that early syphilis is curable usually. The manifestations of late syphilis can be avoided if the disease is discovered while in the latent stage. There are many reasons, economic as well as humanitarian, for the attempts to prevent and even to irradicate this disease. How can it be done other than by means of public education and universal blood tests? Are not the premarital blood tests a step in the right direction which should eventually result in a further reduction of the incidence of lues? If syphilis practically can be irradicated by having everyone's blood tested, and treatment given when indicated, should it not be done?

CLIFTON B. LEECH, M.D.

Providence, R. I.
September 10, 1943

Gentlemen,

A plea for the "detail" and drug salesmen . . . . .

May I submit an earnest plea for publication in your Medical Journal addressed to all doctors?

We know how extremely busy the doctors are in these busy days. How well we know! Sitting in doctors' offices day in and day out—hours at a time—waiting our turn just as a patient does. Sometimes we are only able to make 2 calls an afternoon—and yet we are expected to produce, or else. Believe it or not, sometimes we are of great assistance to the doctor. He needs us as we need him.

May I make a suggestion? Whenever a doctor sees a detail man or a drug salesman in his office, let him come right in—tell the patient it is an important call, give the man 10 minutes and send him on his way. The doctor will not lose time as the percentage of salesman to patients is very small. He will be doing the man a great help—earn his respect and give that man a chance to earn his living just as the doctor.

Doctors, please give us a break.

Thanks,

"One of the Boys"

MEDICAL ADVISORY COMMITTEE TO O. P. A.

At the invitation of the State Director of the Office of Price Administration, the Rhode Island Medical Society has appointed a Medical Advisory Committee to assist the O. P. A. officials in their work of carrying out the war time regulations relative to rationing, particularly as regards the supplemental issuance of rationed commodities for which the physician's approval is required. The committee named by the Council of the Rhode Island Medical Society consists of Dr. John F. Kenney of Pawtucket, who will serve as chairman, and Drs. James H. Fagan and Robert H. Whitmarsh of Providence.

This Committee has already developed what it hopes may be a successful approach to the difficult problem of certification for rationed commodities for ill patients, and at the same time a satisfactory arrangement whereby the requirements stipulated by the physician in such instances may be reviewed by a medical appeal board whenever the certification is questioned by a local board.

Under the plan proposed by the new Medical Advisory Committee, and approved by the State Director of the Office of Price Administration, a uniform all-purpose certificate has been prepared which is being distributed in quantity to each physician. This all-purpose form will provide for certification for supplemental issuance of rationed foods, fuel oil, gasoline, and rubbers. Placing the certificates with the physician should serve as a better control of their use, and at the same time eliminate repeat visits to the physician's office by the patient merely for the purpose of having a certification form filled out.

The program outlined by the Advisory Committee provides that any physician's certificate may be questioned by a local board, but it may not be rejected until it has been reviewed by the State Director and the Medical Advisory Committee. Pending a decision from these authorities the local board shall issue temporary supplemental rations to the patient.

The certification should be signed by the physician ONLY when it is definitely shown that the patient will suffer in health because of the lack of the rationed commodity. It is readily apparent, therefore, that every physician in the State must assume an important obligation in accepting this program to assist the war price and ration boards in their efforts to assure eligible sick or disabled

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CIVILIAN MILK SUPPLY limited

The greatly increased wartime demand for milk, combined with the seasonal decline in production, has made it necessary for the War Food Administrator to limit milk sales. However, present indications are that there will still be enough milk to maintain the normal health of everybody.

The responsibility for allocating the available supply has been placed squarely on the shoulders of the various milk dealers. We wish to assure you that we will do everything in our power to distribute our milk fairly and equitably so that no one will suffer from this limitation order.



H. P. HOOD & SONS

Pioneers in Quality Dairy Products since 1846

MEDICAL ADVISORY COMMITTEE TO STATE O. P. A.

continued from page 253

citizens necessary rationed commodities for the assurance of normal good health.

The uniform all-purpose certificate drafted by the Advisory Committee is as follows:

PHYSICIAN'S STATEMENT FOR SUPPLEMENTAL ISSUANCE OF RATIONED COMMODITIES

This statement subject to review and action by Medical Advisory Committee appointed by the Rhode Island Medical Society.

.....194.....
Month *Day* *Year*

.....
Name in Full of Patient

....
Street Address *City and State*

STATE *FULLY* THE NATURE OF ILLNESS which *prohibits the use* of *non-rationed foods* and requires rationed foods *in addition to regular allowance* of the patient OR which requires warmer room temperatures:

.....

LIST THE ENTIRE AMOUNT OF
RATIONED FOODS REQUIRED BY PATIENT FOR THE FOLLOWING .....DAYS
(*Not to Exceed 60 Days*)

PROCESSED FOODS, JUICES & SUGAR	*Do not mark in these spaces*	MEATS & FATS	*Do not mark in these spaces*
..... lbs.		..... lbs.	
..... lbs.		..... lbs.	
..... lbs.		..... lbs.	
..... lbs.		..... lbs.	
..... lbs.		..... lbs.	

FUEL OIL

A room temperature of .....degrees is required for the patient for the following .....days (Not to Exceed 60 Days).

(to be filled in by Ration Board)

BOARD NO.....Date Issued.....
(*points*)

.....

.....

.....

..... D.O.
..... M.D.
Physician's signature

.....
Street Address

.....
City

Physician's statement certifying need of supplemental issuance of gasoline.....

Nature of illness which requires this additional ration and sign the face of this form.

.....

FOR USE BY MEDICAL SOCIETY ADVISORY COMMITTEE ONLY

Date Reviewed..... Comment:.....

.....

Signed:.....

STATEMENT OF R. I. MEDICAL SOCIETY ADVISORY COMMITTEE

.....

NOTE: All appeals must be returned to State Rationing Officer, Office of Price Administration, Hospital Trust Building, Providence, for final action.

Into the valley of the shadow...AND OUT AGAIN!



IN A NEW GUINEA JUNGLE, Japs on a sneak raid stuck their bayonets seven times into the body of this young American soldier from San Francisco. At the base hospital, the Army doctors pumped literally quarts of blood plasma into the boy. A week later, *he was able to sit up, smoke, and eat comfortably!*



AN EXPLOSION GOT YOUNG H.S., a sailor on a gallant little destroyer in our Navy. A sudden searing flash burned his face, head, arms, shoulders, and hands. The doctors gave him blood plasma. Today, H.S. is ready to go back to his ship . . . *unscarred!* The doctors worked *that* magic after the *blood plasma kept him alive!*



IN THE CORAL SEA, B.S. 18-year-old seaman second class, met the bomb that tore parts of his body to shreds. He was out for five days. By all the rules, he was dead. Five times in 24 hours, B.S. got blood plasma; was operated on; was kept alive with more blood plasma. *And he's back on his feet today!*



K. M. WAS A 19-YEAR-OLD DARTMOUTH FRESHMAN, until he joined the Marines. In the South Pacific, a Jap bullet pierced his abdomen and lodged in his spine. A double blood-plasma transfusion was pumped into his veins; two hours later another transfusion. *He lived. The bullet was removed from his spine!*

BLOOD PLASMA is made from whole human blood. This blood is donated by patriotic civilians to the American Red Cross. It is saving literally tens of thousands of lives. *Have you donated blood?* Countless people have, not just once or twice but regularly. There is no risk, no pain. It takes about 45 minutes and is one of the most humanitarian and satisfying acts you can do.

If you live in or near one of the 33 cities with blood-donor centers, call the American Red Cross today.

This appeal for blood donors is dedicated to the American Red Cross by

OWENS-CORNING FIBERGLAS CORPORATION
TOLEDO, OHIO

GIVE A PINT OF BLOOD AND SAVE A FIGHTER'S LIFE

INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., Chairman; Herbert E. Harris, M.D.; Stanley D. Davies, M.D.; Michael H. Sullivan, M.D.; William P. Buffum, M.D.

OCTOBER MEETING

The Rhode Island Society of Industrial Physicians and Surgeons had their first meeting of the fall season in the Rhode Island Medical Library on October 19, 1943.

At this meeting they were joined by the Rhode Island Industrial Nurses Club. This organization was recently formed and works in close harmony with the Rhode Island Society of Industrial Physicians and Surgeons. It is planned that at all future meetings the nurses will meet at 8:00 o'clock and conduct their business from 8:00 to 8:30. Then the physicians will meet at 8:30 or 8:45, and after a short business meeting, both nurses and doctors will combine for a program of mutual interest.

The speaker of the evening at the last session was Mr. Robert Gillispie of the Walsh-Kaiser Company, who spoke upon the relationships in the plant of the physician and the safety engineer. Mr. Gillispie gave a splendid exposition of what might be accomplished by closer cooperation between the physician and his knowledge of accidents and accident prevention when combined with the ability of the safety engineer to eliminate hazards in and around the plant and peculiar to the occupation. He urged the physicians to know thoroughly all the hazards associated with the particular plants they served and to know best how to treat them and to assist the engineer wherever possible in eliminating serious accidents or continued occupational hazards. The meeting was extremely interesting and following the talk many physicians and nurses asked questions. A lively discussion ensued when several instances were recounted by physicians and nurses.

Following Mr. Gillispie the assembled doctors and nurses heard a talk by Mrs. Doris E. McGowan, of the Division of Women and Children, State Department of Labor, on labor laws as they concerned women and children in industry. Mrs. McGowan expounded at length on the responsibility for determining the age of children in industry. She stressed the fact that a birth certificate alone was not satisfactory proof or not acceptable proof by the Department of Labor that the child was sixteen years of age. The burden of proof rests upon the employer in every instance, and he is urged to accept as employees only those persons who have been certified by the School Department. Several instances of fraudulent age have been uncovered by investigators, and the doctors and nurses were warned as to the best procedures to follow in considering children for work that they are of the legal age and have the proper certificates issued by the school authorities. Mrs. McGowan's talk likewise provoked a lively discussion and a very profitable one.

Dr. Deery of the Department of Industrial Hygiene showed a motion picture in sound entitled, "Take Care of Yourself."

The meeting adjourned after the distribution of pamphlets covering various phases of industrial health work and some pamphlets from the United States Government National Committee for the Conservation of Manpower in War Industries.

EMPLOYMENT FOR PHYSICALLY HANDICAPPED

With the military forces making increasing demands on the services of young adult males and fathers in the middle age group, an increasingly greater number of older men and women will be employed in industry. What should our attitude

Industrial Physicians Meeting

Plans are now being made to hold the regular December meeting of the Society of Industrial Physicians and Surgeons of Rhode Island, and also the State Industrial Nurses' Association, at the Ashton plant of the Owens-Corning Fiberglas Corporation. A tour of this modern industrial plant will be followed by a business meeting there which will be addressed by an outstanding industrial health authority. Details on this important meeting will be sent to all members this month.

be toward their physical defects which they have had for many years and which have not been disabling until the time they applied for examination previous to employment in industry?

Wendell S. Keate, M.D., in the Douglas Aircraft Corporation of California, summarizes unusual findings in the September issue of "Industrial Medicine." He says in part "Qualified and limited employment has been substituted in place of rejection. With this procedure the acceptance of a potential hazard of a physical disability as well as inability is inevitable.

CLINICAL OBSERVATIONS

Obesity: When obesity is not complicated by cardiovascular disease it has proved to be acceptable in younger individuals. In older individuals in general, moderate to severe obesity has proved to be a personal hazard.

Hypertension: Applicants have been accepted with systolic pressures as high as 170 and diastolic pressures of 110 when no demonstrable, myocardial, or renal insufficiency was associated.

Valvular Heart Disease: In younger individuals where there is no myocardial insufficiency associated, this condition is not considered a basis for rejection.

Arteriosclerosis and Myocardial Disease: The degree of pathology and impaired physiology is difficult to determine from an objective examination. If there is no evidence of gross disturbance employment has been allowed.

Coronary Artery Occlusion: These types of vascular diseases offer industry a big headache. The condition indicated may become acute before it improves.

Varicose Veins: The existence of moderate or severe varicosities is a basis for rejection.

Herniae: Small hernia retainable by appliance has been accepted.

Pelvic Disorders: Cases of cystocele, fibroid, or ovarian tumors are basis for rejection. Pelvic inflammatory conditions found in young females have become a major problem.

Dermatoses: Applicants having demonstrable skin lesions should be closely scrutinized. Rejections for this group should depend upon the type of work which they are called upon to do. Psoriasis is not considered a basis for rejection."

More than ever before the pre-employment examination is now considered as a *pre-placement* examination. The aged or handicapped worker must be carefully selected for the job or rather the job must be carefully selected for the worker. He should also be given certain safeguards to be sure that any existent latent pathology will not become aggravated. It is also important to re-check these individuals at frequent intervals and thus to prevent the increase of disability and absenteeism in industry. We have got to resort to more careful scrutiny — more careful placement — more frequent check-ups of our over age or physically handicapped workers.

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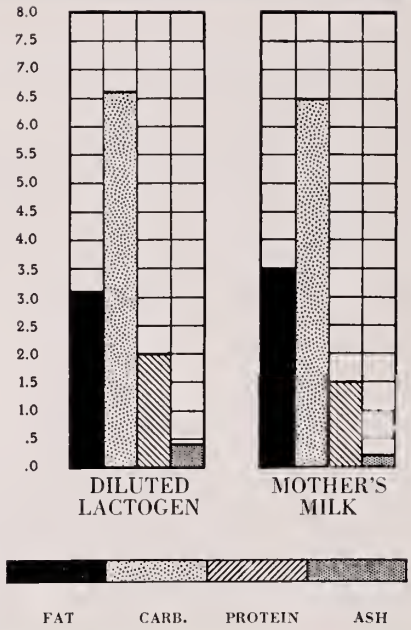


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The cow's milk used for Lactogen is scientifically modified for infant feeding. This modification is effected by the addition of milk fat and milk sugar in definite proportions. When Lactogen is properly diluted with water it results in a formula containing the food substances — fat, carbohydrate, protein, and ash — in approximately the same proportion as they exist in woman's milk.



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★ **"My own belief is, as already stated, that the average well baby thrives best on artificial foods in which the relations of the fat, sugar, and protein in the mixture are similar to those in human milk."—**
John Lovett Morse, A.M., M.D.
Clinical Pediatrics, p. 156.

NESTLÉ'S MILK PRODUCTS, INC.

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NEWS FROM THE WAR FRONT

7,000 DOCTORS NEEDED

The Office of War Information, in an official report issued on October 20, states that the Army and Navy lack adequate supply of civilian physicians, and assert they require an additional 7,000 medical doctors and 800 dentists "to insure even minimal care of the wounded" till the end of this year. The report was based on information from the Army, the Navy, and the War Manpower Commissioner's Procurement and Assignment Service.

Since March the Army has reduced its ratio to 6.6 doctors per thousand men in combat areas, and 4.6 doctors per thousand men in non-battle areas. The changed ratio works out to 53,000 civilian doctors for the Army and the Navy. Of these, about 46,000 had been commissioned as of August 15, but the commissioning of doctors into the armed services is falling behind the monthly quotas assigned.

According to OWI it was stated that many doctors, instead of asking for commissions, are waiting for their numbers to be called in the draft, when they feel sure of being commissioned despite the delay. It was pointed out on behalf of the Procurement and Assignment Service that this is a dangerous practice for the doctor. Application for commission on the eve of induction does not necessarily prevent a doctor from being drafted and undergoing basic training as a private in the Army, or as an apprentice in the Navy. Regular procedure would call for the doctor to remain in training until such time as his commission could be processed. Should he fail to receive a commission, he would continue on the same basis as untrained inductees. Several doctors have gone through basic Army training as privates.

FIRST WOMAN DOCTOR ENLISTS

Dr. Margaret M. Ross of Rumford, wife of Dr. Daniel J. McCarthy, an East Providence dentist, has the distinction of being the first woman doctor in Rhode Island to join the armed forces. Sworn in as a Captain in the U. S. Medical Corps last month, and subsequently assigned to the Post Hospital at Fort Des Moines, Iowa, Dr. Ross is one of the five women doctors in the country at this writing to hold the rank of Captain in the Army, and to be eligible thereby for duty on any war front.

"OUT OF 'JEEP' TRAFFIC"

A. P. O. 689, c/o Postmaster
New York City, N. Y.
September 28, 1943

The arrival today of the July '43 MEDICAL NEWS has prompted me to make a little report on this segment of the Society, isolated on a bluff in a dense mountain jungle. We thumb through the MEDICAL NEWS so avidly to learn the activities and whereabouts of our friends that I am sure, scattered all over the world, they are turning its pages with equal interest.

Capts. Wm. Leet, Geo. Conde, Fred Webster, John Dziob, Sam Clark and Irving Beck, with 1st Lts. Milton Korb and Wilbur Manter, under my command, have left northeastern India and are a two day march beyond the limits of jeep traffic. With us are Capts. I. E. Garber and Ed Greeninger (attached to the 48th as replacements while we were at Murfreesboro). With the appropriate enlisted personnel we form Field Hospital No. 1 of the 48th Evacuation Hospital, so are still under command of Lt. Col. William Mahoney, now commanding officer of the 48th, but he is still with that section running the Post Hospital back on the plains.

We are simultaneously erecting and running a 250 bed hospital, 90% Chinese soldiers as patients. The collection of bamboo sheds and huts under the huge trees of a primeval jungle would hardly be recognized as a hospital by those familiar with the great medical centers. But a hospital it is and a busy one with an enthusiastic personnel.

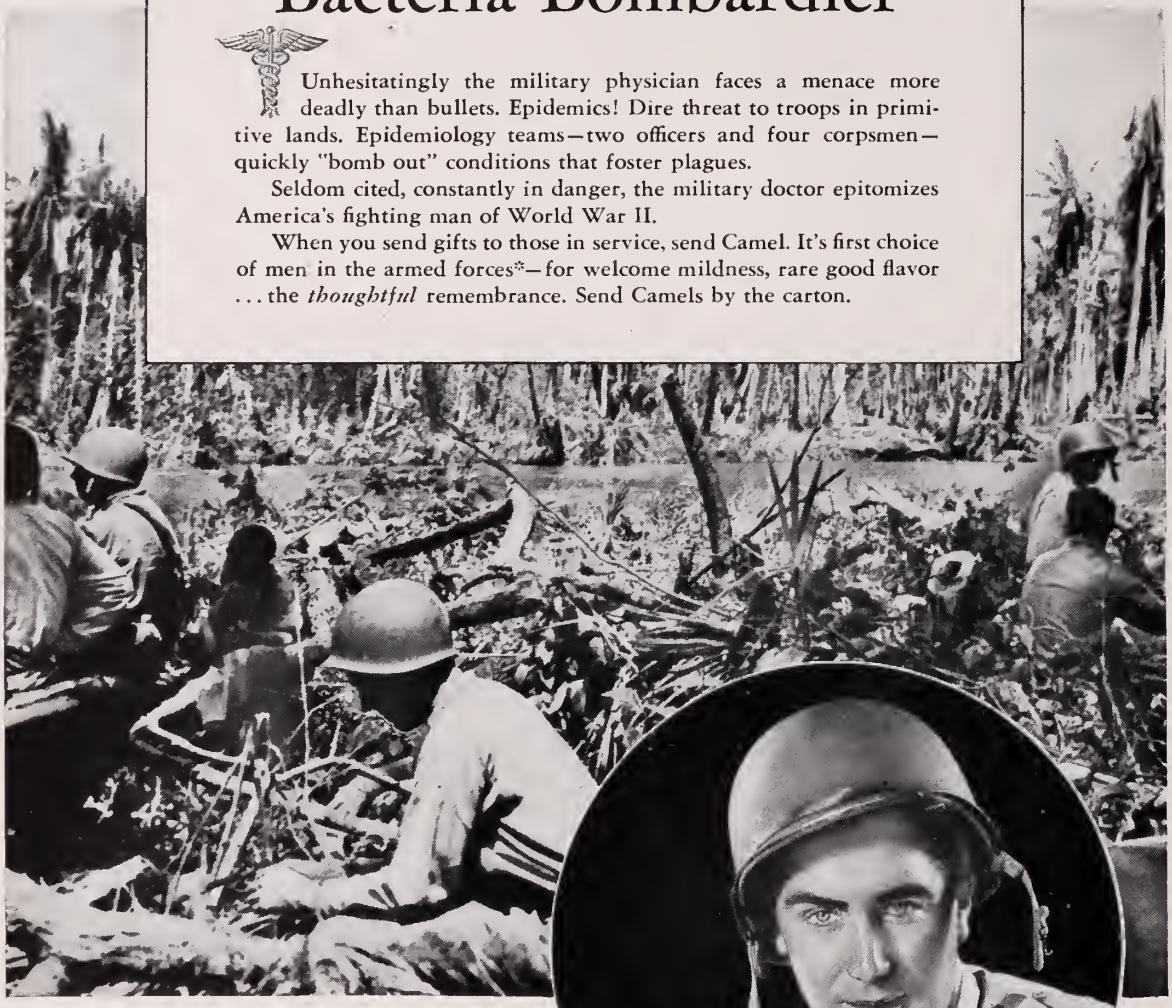
continued on page 263

Bacteria Bombardier

Unhesitatingly the military physician faces a menace more deadly than bullets. Epidemics! Dire threat to troops in primitive lands. Epidemiology teams—two officers and four corpsmen—quickly "bomb out" conditions that foster plagues.

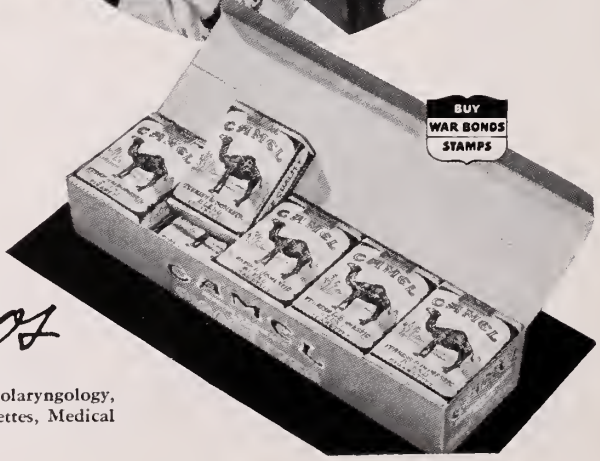
Seldom cited, constantly in danger, the military doctor epitomizes America's fighting man of World War II.

When you send gifts to those in service, send Camel. It's first choice of men in the armed forces*—for welcome mildness, rare good flavor ... the *thoughtful* remembrance. Send Camels by the carton.



FIRST in the Service

*With men in the Army, Navy, Marine Corps, and Coast Guard, the favorite cigarette is Camel. (Based on actual sales records.)



Camel

Costlier Tobaccos

New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Copies on request. Camel Cigarettes, Medical Relations Division, 1 Pershing Square, New York 17, N. Y.

Bill Leet comments that we have a "million dollar site, if it were in New England."

Yours sincerely,

ERIC STONE, Major, M.C.

EYES TOWARD BURMA

With the Indo-China campaign in the offing our 48th Unit must surely have its eyes toward Japanese-held Burma. Latest news, in addition to the letter from Major Stone, from India reveals that Colonel Leedham, who took charge of the Unit following its organization at Fort Devens, has been transferred, and our Lt. Col. William A. Mahoney is the C. O. The Unit has lost two now of its original group, as Drs. Arthur Martin, and Frank Holland, the latter dental officer, have returned to America, and following home visits have been assigned stations at camps here.

Meanwhile the Unit has reportedly acquired a Chinese Lieutenant Colonel who is attached to the surgical staff and who will undoubtedly be a key member in the invasion force. Major J. Murray Beardsley, ill with jaundice for more than a month, was last reported headed for Darjeeling, a mountain resort near Mt. Everest, where his convalescence will undoubtedly be speeded by rest within sight of the majestic Himalayas.

MILITARY ROUNDUP

CAPTAIN FRANCIS E. TEMPLE, MC, is reported to be somewhere in England with a unit which was formed when he was stationed at the Walter Reed Hospital. . . . CAPTAIN JOHN H. GORDON, MC, former secretary of the Pawtucket Medical Association, is reported to have been on the patient roster at a station hospital in Africa, following his participation in the Sicilian invasion. . . . MAJOR JOSEPH C. SMITH, MC, former deputy health officer in Providence, has been transferred from Mitchel Field to the Station Hospital at Langley Field, Virginia. . . . Promoted to the rank of Captain recently were DRS. DONALD DE NYSE, FRANCIS D. LAMB, and ARNOLD PORTER, the last named the son of Dr. Emery M. Porter, President of the Providence Medical Association. . . . MAJOR JEREMIAH A. DAILEY, MC, who spent more than a year at Waikapu in the Pacific, is now assigned to Camp Niantic in nearby Connecticut. . . . After a short stay at Camp Blanding, LIEUT. MAURICE N. KAY, MC, has been transferred to Camp Croft in South Carolina. . . . The new address of Oceanside, California, seems quite appropriate for LIEUT. NICHOLAS POURNARAS, MC, USNR, who was one of Block Island's two doctors at the time of his enlistment last January.

MILITARY ANNOUNCEMENTS

ASSIGNMENTS

LIEUT. CHARLES E. BRYAN, MC, Carlisle Barracks, Carlisle, Pennsylvania.

CAPTAIN EDWARD SELTZER, MC, Carlisle Barracks, Carlisle, Pennsylvania.

LIEUT. ALBERT J. GAUDET, MC, Carlisle Barracks, Carlisle, Pennsylvania.

CAPTAIN MARGARET ROSS, MC, Post Hospital, Fort Des Moines, Iowa.

TRANSFERS

CAPT. LOUIS A. BEAUDOIN, MC, 1621 SU, Fort Custer, Battle Creek, Michigan.

LT. COMDR. JARVIS D. CASE, MC, U. S. Naval Hospital, Charlestown, South Carolina.

MAJOR JEREMIAH A. DAILEY, MC, Station Hospital, Camp Niantic, Connecticut.

LIEUT. PHILIP S. GELLER, MC, O-302036, 709 Medical Hospital Ship Platoon, Camp Stoneman, Calif.

LIEUT. ALBERT E. GEREMIA, MC, USNR, U. S. Naval Medical Supply Depot, Pearl and Sands Streets, Brooklyn, New York.

CAPT. WALTER E. HAYES, MC, 28th General Hospital, Moore General Hospital, Sevannanoa, North Carolina.

LIEUT. MAURICE N. KAY, MC, 319th Station Hospital, Camp Croft, South Carolina.

MAJOR JOSEPH C. KENT, MC, Dispensary, 3rd Bn., Truck Regt., Fort Benning, Georgia.

CAPT. FRANCIS D. LAMB, MC, Army Air Base, Reading, Pennsylvania.

LT. COMDR. FRANK B. LITTLEFIELD, MC, Service Force, Att'n Fleet Subordinate Command, N. O. B., Norfolk, Virginia.

LIEUT. AMEDEO MASTROBUONO, MC, USNR, U. S. N. Mobile Hospital No. 5, c/o P. M., San Francisco, Calif.

LIEUT. ADOLPH J. NADWORNY, MC-Af, Air Force Regional Station Hospital, Coral Gables, Fla.

LIEUT. NICHOLAS POURNARAS, MC, 4th Bn., 14th Marines, 4 T Marine Division, Camp Pendleton, Oceanside, California.

MAJOR JOSEPH C. SMITH, MC, Station Hospital, Langley Field, Virginia.

LT. COMDR. H. FREDERIC STEPHENS, MC, USNR, Medical Depot, Headquarters, Sub-Area, Marine Area, Construction, E.M.A.W., Navy 140, c/o Fleet P. O., San Francisco, California.

LT. COMDR. ERNEST THOMPSON, MC, USNR, Navy 147, Fleet P. O., New York, N. Y.

LT. (j.g.) WILLIAM H. TULLY, MC, USNR, U. S. S. Wadleigh, Bath Iron Works, Bath, Maine.

LT. COMDR. HAROLD WILLIAMS, MC, U. S. Naval Training Station, Great Lakes, Illinois.

CAPT. MARK A. YESSIAN, O-502633, 239th Engineer Combat Battalion, Med. Det., Camp Forrest, Tenn.

PROMOTIONS

LIEUT. DONALD DENYSE promoted to the rank of Captain.

LIEUT. FRANCIS D. LAMB promoted to the rank of Captain.

LIEUT. ARNOLD PORTER promoted to the rank of Captain.



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If you have mislaid or never received the Guide Policy which was sent to you, drop us a line and you will have it by return mail.

Make sure that the policy you carry is the one you want — Make sure it is Non-Cancellable — Check it against the buyer's guide.

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FROM THE SECRETARY'S DESK

WILLIAM P. BUFFUM, M.D.

122 Waterman Street Providence

NEW FELLOWS OF SOCIETY

There has been an excellent response to the appeal of the President to members of district societies who are not members of the State Society to register for fellowship at this time. Within the past month the following doctors have been enrolled as fellows of the Rhode Island Medical Society and thereby as members of the American Medical Association: Drs. James A. Alston, C. Thomas Angelone, Angelo Archetto, Vera M. Behrendt, George W. Bellano, Reginald H. Boucher, Temple Burling, Maurice J. Butler, Charles E. Bryan, Robert E. Carroll, Pasquale J. Celestino, George V. Coleman, Alfred Conte, Vera Winston Fish, Louis J. Fuhrmann, William P. Giles, Sidney S. Goldstein, Eugene N. Granger, H. Gulesserian, Albert C. Henry, William A. King, George E. Kirk, Anne L. Lawton, George R. Mankis, Joseph Marks, Morris Marks, Vincent J. Mattera, Francis H. McCaffrey, James P. McCaffrey, James F. A. McGinn, Llewellyn J. McGovern, James R. McKendry, Frank A. Merlino, Louis A. Morrone, Gustavo A. Motta, Rose C. Munro, Adolph J. Nadworny, John A. Paterson, Charles Potter, William A. Reid, Edward A. Ricci, Mildred I. Robinson, Vincent P. Rossignoli, Warren H. Ruhmann, John C. Sarafian, Ciro O. Scotti, James F. Sullivan, Ralph V. Sullivan, Adrien G. Tetreault, William H. Tully, Jr., Howard W. Umstead, Charles E. White, and Joseph E. Wittig.

HONORS CONFERRED

In recognition of thirty years as members, Dr. William M. Muncy and Harry C. Messinger, both of Providence, were elected senior members of the Academy of Ophthalmology and Otolaryngology at the annual meeting of the Academy in Chicago, October 10-12.

Cited for outstanding work in public health education, John E. Farrell, executive secretary of the Society and also of the Providence Medical Association, was one of six nominated by the Section on Public Health Education and subsequently elected to Fellowship by the Governing Council of the American Public Health Association. Mr. Farrell was also honored locally recently by election as 2nd vice president of the R. I. Conference of Social Work.

Dr. Peter F. Harrington, director of tuberculosis in the Providence Health Department, was appointed last month as Chairman of the Health Division of the Providence Council of Social Agencies.

Dr. Lucius C. Kingman, former president of the Society, has been named by the Mayor of Providence to fill the unexpired term of Dr. John M. Peters, resigned, as a member of the Board of Hospital Commissioners.

VISITORS FROM MEXICO

At the invitation of Dr. Clifton B. Leech, chairman of the Medical Advisory Committee for the Bureau for the Handicapped, a group of Providence doctors attended a luncheon meeting on October 6 for Drs. Rafael Moreno-Valle and Vincente Roqueni who were visiting the city by direction of the Minister of Public Health of Mexico for the purpose of obtaining ideas which will aid them in developing a rehabilitation program for adults in their country. The local delegation included, in addition to Dr. Leech, Drs. Herbert E. Harris, William A. Horan, Peter F. Harrington, Raymond F. Hacking, William P. Buffum, and the executive secretary, Mr. Farrell.

NEW HAMPSHIRE BLUE SHIELD

At its Fall meeting the House of Delegates of the New Hampshire Medical Society authorized its Committee on Medical Economics, which had reported a plan for statewide medical service on a voluntary non-profit basis, to make such changes as may be necessary and to put the plan into effect. The program will be known as the Blue Shield, and it will be directly operated by the State Medical Society which estimates it must raise ten thousand dollars to inaugurate the plan.

Certified Milk

The Government and health officials are placing particular emphasis today upon nutrition as an essential factor in the war effort.

For greater nutritional value, recommend milk certified by the medical profession. Its quality and reliability are assured.

•

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Certified Milk

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	Whiting Milk Co.	GA 5363

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MEDICAL LIBRARY NOTES

COMMITTEE ON THE LIBRARY:
Herbert G. Partridge, M.D.; Samuel Adelson, M.D.; Adolph W. Eckstein, M.D.

THE Librarian of the Rhode Island Medical Society Library announces the recent addition of the following books:—

DERMATOLOGY

Oliver S. Ormsby & Hamilton Montgomery—Diseases of the Skin. Phil., 1943. 6th ed. rev.

NERVOUS SYSTEM

Joseph L. Fetterman—The Mind of the Injured Man. Chic., 1943.

Studies of the VIII Nerve, by the Research Study Club of Los Angeles. St. L., 1937.

THERAPEUTICS

Logan Glendening & Edward H. Hashinger—Methods of Treatment. St. L., 1943. 8th ed.

SPECIAL GIFTS

Gift of CHARLES L. FARRELL, M.D.

Jack E. Weiss, editor & others—1021 Answers to Industrial Health and Safety Problems. Cleveland, Ohio, 1943.

FLAG PRESENTED TO LIBRARY

A silk American flag, one of the finest available, and a supporting standard topped with a gold eagle, was presented to the Library by Dr. Emery M. Porter, President of the Providence Medical Association, at the conclusion of the Association's regular meeting on October 4. The flag will be displayed from the platform in the auditorium on the occasion of medical meetings there.

The gift is singularly appropriate in these times when the defense of the flag is uppermost in everyone's mind, and the Committee on the Library, in behalf of the State Medical Society, acknowledges this important addition to the Library equipment with deep appreciation.

BOOK REVIEWS

NEW AND NON-OFFICIAL REMEDIES 1943. American Medical Association, 535 North Dearborn Street, Chicago, Ill.

This contains descriptions of articles which stand accepted by the Council on Pharmacy and Chemistry of the A. M. A. on Jan. 1, 1943.

The material used in this book is carefully examined and used only if the facts as presented are proved to be true. A description of the drug action and uses, doses, tests and standards are also given. Besides the book itself, supplements are edited during the year which keep abreast with new and additional information.

For quick information this will prove to be an excellent reference book for any medical library.

METHODS OF TREATMENT — by Logan Glendening, M.D., and Edward H. Hashinger, A.B., M.D., both Clinical Professors of Medicine, University of Kansas. Eighth Edition.

An introductory note states that "this book is planned to furnish an outline of all the methods of treatment in internal medicine". Twelve collaborators have written chapters on special subjects. There are one hundred and thirty-eight illustrations. It is a sizable book of over one thousand pages in two parts with twenty-five chapters. Part I is devoted to general therapeutics, Part II to the application of therapeutics to particular diseases.

The authors frankly express personal views on controversial subjects: for example, "bromides properly administered are probably still the best drug we have for epilepsy". I do not believe this opinion will be generally accepted.

Of course in these days of frequent contributions to, and modifications of, therapy no bound volume can be up to the minute. The fact that this work has reached its eighth edition in two decades is an undeniable tribute. It is a valuable basic volume, especially for the general practitioner and internist.

WILLIAM S. STREKER, M.D.

Will the members who have the following journals from the Medical Library kindly return them at their earliest convenience as they have been requested:—

Archives of Neurology & Psychiatry, March 1943 War Medicine, February 1943.

DISTRICT SOCIETY REPORTS

KENT COUNTY

A meeting of the Kent County Medical Society was held at the home of the President, Dr. Arthur E. Hardy, on October 14.

The proposals of the House of Delegates of the Rhode Island Medical Society were read and discussed. It was voted that action on these recommendations should be taken at the next meeting.

Dr. Charles J. Ashworth, of Providence, associate surgeon at Rhode Island Hospital, read a paper on "Acute Surgical Conditions Within the Abdomen." Some of the conditions presented were acute appendicitis, chronic acute perforated peptic ulcer, acute pancreatitis with gall bladder infections, and peritonitis. Dr. Ashworth also reported signs, symptoms and differential diagnoses, and he related some personal cases with results. The paper proved very interesting to the members, and it evoked general discussion.

Benjamin F. Tefft, M.D.,
Secretary

PROVIDENCE MEDICAL ASSOCIATION

The first regular meeting of the Providence Medical Association following the summer recess was held at the Medical Library on Monday, October 4.

The Secretary reported that tributes for the Association's permanent records have been filed with him as follows: By Drs. Frank T. Fulton, and Robert C. Robinson in memory of Dr. Murray S. Danforth; by Drs. Charles J. Ashworth and John G. Walsh in memory of Dr. Charles F. Gormly; by Dr. Halsey De Wolf and Lieut. Comdr. William P. Davis in memory of Dr. Frederic V. Hussey.

Twelve new members were elected to membership as follows: Active—Reginald H. Boucher, M.D., Charles E. Bryan, M.D., Robert E. Carroll, M.D., Walter R. Durkin, M.D., William P. Giles, M.D., John J. Lury, M.D., Llewellyn J. McGovern, M.D., Rose C. Munro, M.D., Adolph J. Nadworny, M.D., Warren H. Ruhmann, M.D., William H. Tully, M.D.; and Associate—Laurence A. Senseman, M.D.

Dr. Emery M. Porter announced the appointment of Dr. Philip Batchelder to fill the unexpired term of the late Dr. Murray S. Danforth on the Executive Committee of the Association.

The scientific program consisted of the presentation of two papers, the first by Dr. Louis Goodman of the State Hospital, on "Chronic Hypertensive Encephalopathy", and the second by Dr. B. Earl Clarke of the Rhode Island Hospital on "The Rh Factor: Its Role in Erythroblastosis of the Newborn and in Transfusion Reactions."

Dr. Goodman classified the causes of chronic hypertensive encephalopathy under three headings: The "h" or hormonal factor; the "c" or central factor; the "r" or renal factor.

He reported six cases with autopsy findings. The duration of life after onset of symptoms varied from ten months to thirty-one years. The basis of the disorder is arteriolarsclerosis with resultant areas of ischemia, edema and hemorrhage. He differentiated the condition diagnostically from brain tumor, schizophremia, cerebral arteriosclerosis and dementia paralytica. The paper was discussed by Dr. Earl Clarke and Walter Weigner.

A series of slides presenting graphically the mechanism by which the Rh factor causes intragroup transfusion reactions and erythroblastosis of the newborn was presented. Credit for preparing these graphic slides was credited to Dr. Edward S. Brackett.

It was pointed out that the erythroblastotic infants are produced entirely, or almost entirely, by Rh negative mothers and Rh positive fathers. The mother absorbs the Rh antigenic factor from the fetus. The anti Rh substance produced by the mother find its way to a certain extent into the circulation of the fetus, causing various hemolytic disorders. It was pointed out that an awareness of the Rh factor would eliminate about 90% of the intragroup transfusion reactions. A group of Rh negative donors should be available to all obstetrical services. Particularly the mother of an

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erythroblastotic fetus should be transfused with only Rh negative blood.

FRANK W. DIMMITT, M.D.,
Secretary

PAWTUCKET MEDICAL ASSOCIATION

A business meeting of the Pawtucket Medical Association was held at Memorial Hospital on Thursday, October 21. The recommendations of the House of Delegates of the State Medical Society were reported by Dr. James L. Wheaton, vice president of the Society. No action was taken on the recommendations.

WASHINGTON COUNTY

The regular meeting of the Washington County Medical Society met on October 13th at the Elm Tree Inn, Westerly, Rhode Island.

The report of the meeting of the House of Delegates on September 23, 1943 was read and also a letter from Dr. William P. Buffum asking for action on several matters relating to it.

The Society adopted the recommendation that all new members be required to join both the district and state medical societies at the same time. This has been our policy for several years.

Dr. Louis C. Cerrito was appointed to serve as a legislative officer to assist the Committee on Public Laws.

Attention was called to the appointment of Dr. Roland Hammond of Providence as chairman of the Committee on Medical Defense and Grievance.

Dr. B. Earl Clarke, Pathologist of the Rhode Island Hospital, was the speaker. His subject was, "The Sternal Biopsy; Its Application in the Diagnosis of Obscure Blood Conditions." It was illustrated by lantern slides of microfilms, first a group of normal blood slides and then those of aplastic and hyperplastic anemias, leukemias and tumors.

It was a carefully prepared and well presented paper, and it was greatly enjoyed by those present.

After the meeting sixteen members sat down to a fried chicken dinner.

JULIANNA R. TATUM, M. D.,
Secretary



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*Himes, *Medical History of Contraception*

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Tell Daddy not to worry, Doctor. The men in Washington are doing everything in their power to provide the folks who make S-M-A (that's my brand) and all the other manufacturers of scientific infant formulas with enough cans, enough special fats, and enough other ingredients to give us babies our full quota of nutrition.

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Rhode Island MEDICAL JOURNAL

THE N.Y. ACADEMY OF MEDICINE
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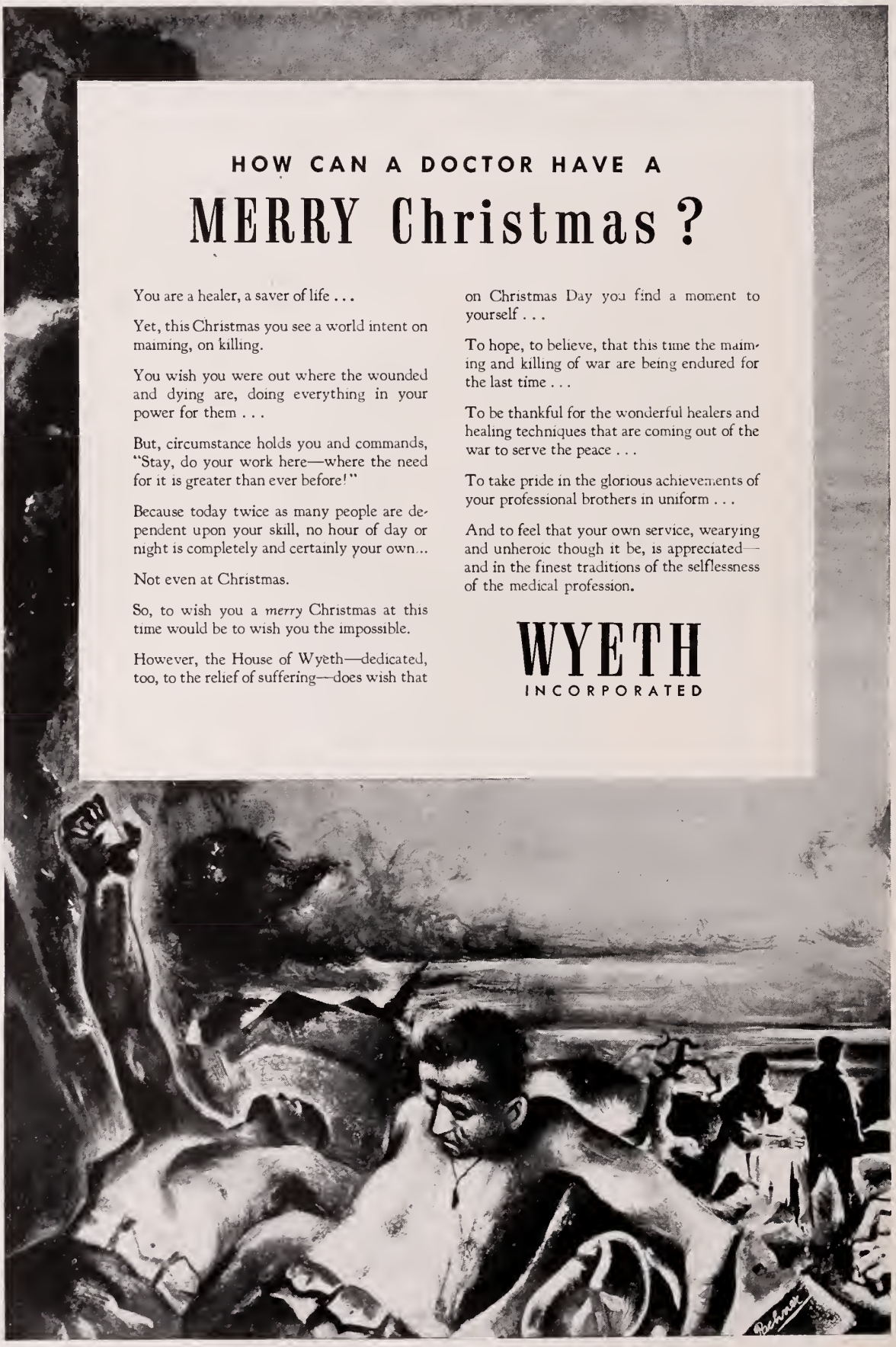
December 1943



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THE RHODE ISLAND MEDICAL SOCIETY



HOW CAN A DOCTOR HAVE A

MERRY Christmas?

You are a healer, a saver of life . . .

Yet, this Christmas you see a world intent on maiming, on killing.

You wish you were out where the wounded and dying are, doing everything in your power for them . . .

But, circumstance holds you and commands, "Stay, do your work here—where the need for it is greater than ever before!"

Because today twice as many people are dependent upon your skill, no hour of day or night is completely and certainly your own...

Not even at Christmas.

So, to wish you a *merry* Christmas at this time would be to wish you the impossible.

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Do Your Part

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HOW YOU CAN HELP YOUR DOCTOR:

1. See your Doctor in his office whenever possible to avoid house calls. Call his office during hours (preferably talk with his secretary) to ask for an appointment at a time most convenient for him—and then be PROMPT.

2. If a house call is **absolutely necessary** call your Doctor around 8:00 o'clock in the morning. Help him plan his calls geographically to avoid unnecessary travel.

3. Remember that a person with a temperature of 100° or over in the morning may be expected to have a higher temperature in the afternoon, so don't delay until you take the afternoon temperature before calling the Doctor.

4. DON'T call your Doctor at night or on Sunday, except in an emergency or for serious illness. His hours are long and strenuous, and he too needs time for rest and relaxation in order that he may continue his work.

5. Don't abuse the privilege of obtaining advice by telephone. It takes the Doctor as long sometimes to converse by telephone as it would for him to see the patient in his office. When you do telephone him, have a pencil and paper ready, state your case concisely, and then listen carefully to instructions to minimize repetitions. Remember—your 'phone call is taking time alloted to another patient at the Doctor's office.

6. If medical services are not available immediately IN AN EXTREME EMERGENCY, take the patient to a hospital —If he can be moved safely!

7. If your Doctor advises hospital care for you, go promptly, and don't overstay your time or demand special favors. To do so may deprive another patient more in need than yourself.

HOW YOU CAN HELP YOURSELF

1. Don't neglect an illness or injury that may develop into something serious. Take care of minor cuts and sores early. Train yourself to be prepared to care for minor ailments. Take the complete Red Cross home nursing course that you may assist intelligently in the care of your family in time of illness.

2. Get your rest daily—8 hours sleep if possible. You don't catch up on lost sleep; therefore keep on a regular schedule every day.

3. Guard against departures from your custom in matters of clothing and exposure to avoid upsetting your resistance to colds and infections.

4. If you find that you have a cold coming on, or have a sore throat, get off your feet. A day in bed keeping warm at the onset of such a threatened illness, plus the drinking of liquids, will go a long way toward halting it. If anything over a slight temperature appears, talk with your doctor, particularly if the condition progresses or continues. If you have an active cold or contagious disease, stay away from other people to prevent the spread of the illness.

5. Take advantage of such preventive measures as inoculations against typhoid, diphtheria, whooping cough, and smallpox.

6. Avoid such health hazards as carelessness,drinking uncertain water or un-pasteurized milk, over-eating, and eating of questionable or stale foods. Eat regularly and slowly. Avoid strenuous exertion after eating, or for that matter, at any time if you are not accustomed to it. Walking is an excellent form of exercise that everyone can enjoy.

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PROVIDENCE



DECEMBER... the star of Bethlehem and the bombs of Pearl Harbor... the Prince of Peace and the god of war ☆ Christmas will have little meaning to the thousands of physicians who serve their country and perhaps to thousands more who strive to carry on at home. There is little time for exchange of pleasantries in the grim business of winning a war ☆ But the Christmas Season will come again when the forces of evil are dead—when man again will do unto others as he would have done unto him.

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXVI DECEMBER, 1943 No. 12

SPEAKING FOR NEW ENGLAND

THE Medical Societies of the States of Rhode Island, Maine, New Hampshire, Vermont, Massachusetts, and Connecticut, through their properly appointed representatives, have studied Senate Bill 1161 now before the Congress of the United States, and they express themselves regarding this proposed legislation as follows:

We approve of the broad medical objectives of the Act that we interpret to be an attempt to improve the health of the people. As a basis of our approval we cite the progressive leadership which the physicians of New England have always shown in the development of public health enterprises. For more than fifty years we have consistently supported the plea for the establishment of a National Department of Health with a Secretary in the President's Cabinet, under whom would be coordinated many important public health programs, exclusive of the Army and Navy. These are now scattered through various departments and bureaus of the Federal government and already play a large role in the provision of medical care for the people of this country.

We approve of the use of the insurance principle on a voluntary basis as a means to aid the individual to budget against the cost of medical care. We maintain that when insurance programs are not directly under the supervision of the medical profession by whom medical care is to be rendered, they should provide for cash benefits to be paid to the individual, for we firmly believe that the citizens of New England are capable of using cash benefits to pay the cost of medical care.

We believe that S. 1161 does not provide for the sound development of a National Health Program. It is implied by the Act that the distribution of compulsory savings managed by Federal authorities will guarantee better health for all the people. We sincerely doubt that such an objective can be realized in this way. In the New England States, judged by any standards with which we are familiar, there is no need to revolutionize the habits of the people in their methods of obtaining medical care.

Private enterprises in the field of voluntary prepaid medical and hospital insurance are increasing rapidly. These facilities should be utilized by the States, if necessary through Federal grants-in-aid, so that each State can purchase medical care for those who are not able to purchase it for themselves. This we believe to be a development that would be acceptable to the New England people, for thereby medical care could be provided even for the indigent who are public charges, a provision most desirable in those communities that have been unable or unwilling to meet this obvious responsibility.

We shall be glad to work out plans with representatives of the Federal and State governments to improve the health of all the people, but we should expect that any plans that might be devised would take full advantage of existing agencies and should be developed within the social patterns that are well understood by the people.

THE REHABILITATION CENTRE

ALEXANDER P. AITKEN, M.D.

The Author. *Alexander P. Aitken, M.D., Chief, Supervisory Staff, The Rehabilitation Center of the Liberty Mutual Insurance Company; Member, American College of Surgeons; Member of the American Association for Surgery of Trauma; Diplomate of the American Board of Orthopedic Surgery.*

A COMPLETE industrial rehabilitation centre, which is the first of its kind, was founded in Boston by the Liberty Mutual Liability Insurance Company in June, 1943. The purpose of this institution was to provide for adequate medical aftercare in cases disabled as a result of an industrial accident. It was our feeling that many cases of prolonged or even permanent disability could be prevented, or at least the length of disability and the degree of residual disability lessened, if early and adequate therapy was given.

The immediate care, whether rendered in a doctor's office or at a hospital is usually promptly and adequately administered. However, when the patient is discharged home and becomes ambulatory, progress often slows up or ceases altogether. This may be due to several factors. In some instances the patient is not given or fails to perform any type of exercise, either for the body as a whole or for the injured member. Failure to perform the former results in an increase of body weight and a general loss of muscle tone, both of which definitely prolong the period of disability. Often the patient fails to exercise the injured part because of actual pain or fear of pain. More often the patient is given and does attempt to follow a prescribed series of exercises, but even in these cases little progress may be made, either because the patient has not been properly instructed in detail or his exercises have not been supervised. Patients soon learn to compensate for lost motion and may feel that they are exercising properly, while the injured part is actually not being moved. This failure to exercise the injured member results in increasing muscle atrophy and joint fixation. The longer either condition persists, the longer the period of disability and the poorer the chance of eventual restoration of normal function becomes.

Failure of physical improvement soon leads to deterioration in mental attitude. Fear that he may have lost his job, or even the more serious fear that he may never return either to his regular position or to any type of employment, lowers the individual's morale; as his depression deepens, he becomes less receptive to any type of treatment and is less apt to show the enthusiasm and cooperation so essential to his eventual recovery. As he cannot notice improvement, he becomes less diligent in his exercises. A vicious cycle is thus established, which is most difficult to break. It is the purpose of the Centre to give the patients adequate medical aftercare, whereby no opportunity for either physical or mental deterioration is given.

Importance of Medical Supervision

Careful medical supervision is imperative in the operation of such a centre. The great majority of cases will consist of fractures, amputations and injuries to joints, muscles, tendons, peripheral nerves and bursae. Consequently, the physician in charge should be well trained in the field of traumatic surgery. All patients must be carefully examined on admission and a complete diagnosis of the injury made. Not infrequently, the diagnosis with which the patient arrives may prove incorrect. Other conditions, such as reflex vascular spasm, may be present. The admitting physician thus must determine whether or not further surgery is needed before the patient attends the Centre. Many cases sent to the Centre are of several years' duration, having fixed joints and considerable muscle atrophy, and these cannot be rehabilitated. The surgeon, therefore, must determine which cases are and which are not to be admitted. In many cases residual deformity and loss of motion are inevitable; an appraisal then has to be made as to the amount of recovery that can be expected. When an end result has been reached, a decision has to be made as to when treatment should be discontinued. In some instances, although surgery may be indicated, it is often advisable to regain muscle power first. In other cases, it may be found during the course of treatment that surgery, which had not been anticipated, would prove beneficial. Finally, the surgeon must check the progress of each patient and direct the treatment according to the progress made. This work, at the present time, is

being carried out at the Centre by two orthopedic surgeons.

Departmental Organization of Centre

The Centre is made up of two correlated departments, comprising physical and occupational therapy. It is essential that both departments cooperate and be well aware of what each department is doing.

The physical therapy department is headed by a thoroughly trained physiotherapist, who has two assistants. The mechanical equipment is quite complete. Almost any form of physical therapy can be administered. Many cases, particularly when acute, must receive physiotherapy before they can be sent to the workshop.

The occupational therapy department is likewise headed by a trained technician who has a corps of assistants. In this department the patient does actual work, within his limitations to do so. Attention is focused on the lost motion and the work directed toward its recovery. It is our intention to eventually give each patient work to do which simulates his regular work as closely as possible. At the present time the patients build such objects as waste baskets, sewing cabinets, end tables, wall lamps, smoking stands and foot stools. The carpenter shop is complete. No power driven tools are used. The creation of these finished articles is a tremendous stimulus to the patient. The depressed, belligerent and complaining patient, once having found that he is able to use his hands, soon forgets the chip on his shoulder and a definite improvement in morale develops. Often the patients become so engrossed in their work that they must be watched carefully for muscle fatigue; not infrequently such fatigue is discovered in the physiotherapy department and the amount of work in the work shop is then cut down. Cooperation between the two departments is thus of vital importance.

When patients have reached their work tolerance they are allowed to rest. Recreation is provided in the form of billiards, horse shoe pitching, darts and the like. These games are also used as a form of recreational therapy, the patient being instructed in the playing of these games to use the injured member so as to hasten the restoration of motion.

Regulations for Patients

All patients who enter the Centre do so voluntarily and only with the consent or recommendation of their attending physician. There is no direct control over the patients, in that they may accept or reject treatment at the Centre, or discontinue treatment if they so desire. If, in the course of treatment, further surgery becomes indicated, the case is referred back to the attending physician.

The patients report daily and are expected to spend the greater part of the day at the Centre. Hotel accommodations are provided for the out of town cases and transportation is furnished the local cases who cannot travel by street car. Dinner is provided in a nearby restaurant for all patients.

Study of Cases Admitted

Since the opening of the Centre four months ago sixty-eight cases have been examined for admission. One case refused treatment. Four cases needed surgery before treatment could be started and were referred back to the attending physician. Of the sixty-three cases admitted, twenty-three have been discharged. Six have been temporarily discharged for further surgery, two for resection of neuromata, one for plastic repair of the palm of the hand, and three for sympathectomy to relieve reflex vascular spasm. At present there are thirty-four cases receiving active treatment.

Of the sixty-three patients admitted there were ten female and fifty-three male patients. The average age of the female patients was thirty-seven years, that of the male patients forty-seven years. The average length of time from the date of accident to the date of admission was seven months.

Table one shows the ages of the discharged patients by decades. It can be seen that almost one-half of our cases had passed the fiftieth year.

Table I

Age:						
17-20	20-30	30-40	40-50	50-60	60-70	70-80
1	4	4	3	5	5	1

Table II gives a brief resumé of the history, progress, and end results of the discharged cases. There were, then, fourteen cases capable of returning to their original work. Ten patients returned to their regular work. Most of these had serious injuries. One returned to a better position at better pay. One was inducted into the Army following an amputation and multiple compound fractures of the fingers. Two patients were admittedly capable of returning to work. One, a sixty-nine year old machinist, was financially able and wished to retire from work. The remaining patient, a married woman, was doing war work and did not wish to return.

Three cases returned to light work, all of whom had serious injuries. Two of these still showed some limitation of motion following multiple frac-

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Table II

File No.	Age	Sex	Months Since Accident	Diagnosis and Treatment Before Admission	Mental Attitude on		Days in Clinic	Physical Condition on Discharge	Work When	
					Admission	Discharge			Injured	Discharged
55	32	F	3	Trigger thumb—Resection of sheath	Normal	Normal	11	Normal	Machine operator	Does not intend to return to work
40	26	M	17	Compound avulsion of tendo Achilles	Normal	Normal	9	Unimproved	Tractor spreader	Did not stay for treatment
37	65	F	3	Trigger thumb—Resection of sheath	Normal	Normal	42	Normal	Candy packer	Same position
30	62	M	13	Old Fracture of humerus. Radial and median nerve paralysis. Septic wrist joint.	Depressed, belligerent	Same	54	Slight improvement in hand	Quarry worker	Did not continue treatment
25	29	M	1½	Amputation of both phalanges of thumb.	Depressed	Normal	21	Excellent grip	Lathe operator	Same position
22	61	M	7	Dislocation of shoulder. Rupture of supra-spinatus tendon—sutured	Depressed	Normal	72	Normal motion and strength	Gas station operator	Same position
20	62	M	1½	Colles fracture, left. Old fracture of left scaphoid. Marked limitation of motion.	Normal	Normal	52	Improved	Tube packer	Light work
19	20	M	8	Compound fractures of second, third, fourth and fifth fingers. Laceration of extensor tendons of second, third and fourth fingers. Amputation of distal two phalanges of midfinger.	Normal	Normal	12	Marked improvement	Spreader	Inducted into Army
16	17	M	7	Fracture of humerus. Radial nerve palsy. Open reduction.	Normal	Normal	55	Normal motion, slight residual palsy	Spreader	Same position
14	73	M	4	Colles fracture in malposition. Old arthritis of hands. Loss of shoulder motion.	Normal	Normal	98	Slight loss of shoulder and finger motions	Dishwasher	Same position
11	30	M	7	Fracture of right humerus, radius and ulna. Much muscle atrophy.	Normal	Normal	17	Improvement in motion	Wire painter	Light work
10	35	M	6	Fracture of fifth metatarsal. Normal motion. Persisted in using cane.	Apprehensive	Normal	9	As on admission	Elevator operator	Better pay and work
7	69	M	7	Colles fracture in malposition. Loss of motion in wrist and shoulder.	Normal	Normal	100	Improvement in shoulder and wrist motion	Machinist	Did not wish to return to work
6	42	M	11	Chronic bursitis of right shoulder. Motion nearly normal.	Very apprehensive	Normal	9	Shoulder motion normal	Core driller	Same position
5	55	M	8	Compression fracture of twelfth dorsal vertebra. Bilateral thrombosis of femoral veins. Arthritis of spine. Ligation of veins. Cast.	Normal	Normal	97	Marked improvement	Floor hand	Light work
4	58	M	4	Colles fracture, left. Fracture of external malleolus. Marked loss of wrist, forearm and shoulder motion.	Normal	Normal	96	Normal motions in all joints	Porter	Same position
42	50	M	2	Amputation of one and one-half phalanges of left mid-finger.	Normal	Normal	37	Normal motions in all joints	Stock fitter	Same position
27	42	M	6	Fracture of head of left radius—cast	Normal	Normal	5	Five degree loss of motion	Newspaper circulation	Same position
32	31	M	3	Bimalleolar fracture of ankle	Normal	Normal	12	Ankle motion nearly normal	Brewery worker	Same position
28	46	M	6	Bilateral fracture of oscalcis	Normal	Normal	27	Loss of subastragular motion	Electrician	Has not returned to work
53	53	M	2	Intercondylar fracture of proximal phalanx of index finger into joint with displacement. Old amputation of middle and ring fingers.	Normal	Normal	60	Still has loss of motion	Molding machine operator	Has not returned to work
38	59	M	6	Fracture of both bones of leg	Normal			Developed intestinal obstruction due to cancer. Died.		
45	57	M	12	Amputation of right ring finger. Loss of motion in wrist, elbow and shoulder.	Extremely neurotic	Same	13	Unimproved	Helper	Has not returned to work

tures. Two cases have been discharged from the Clinic with permanent loss of motion. One, an electrician, shows loss of subastragular motion following bilateral fractures of the oscalcis. The other, a molding machine operator, had previously lost two fingers and received a compound fracture of the proximal phalanx of the index finger into the joint, with displacement, and resultant loss of flexion of this finger. Neither could be further benefited by treatment and neither has returned to work.

Three discontinued treatment voluntarily, one because he did not wish to remain in Boston away from his family. The second was a psychoneurotic whose resultant loss of motion of the entire upper extremity was out of proportion to the original accident, an amputation of a ring finger. The third was a depressed, belligerent man with a badly crippled hand, who had received rather poor surgical treatment prior to admission; he was unable to get along with the personnel of the Centre or with his fellow patients.

The last patient developed intestinal obstruction from a carcinoma and died.

The average length of stay at the Centre for discharged cases was six and one-half weeks in the improved cases, and four and one-half weeks in the unimproved cases.

Results Have Been Successful

It may be seen from the above that our results have been quite successful, especially when one considers that the Centre has been functioning only four months, and also that most of our cases have been in the upper age bracket, with an average duration of time elapsed from accident to admission to the Centre a period of seven months Much more impressive results can be obtained when cases are seen in their early stages, before muscle atrophy, joint fixation and neurosis or depression have been allowed to develop.

There are thirty-four cases now under active treatment. The various diagnoses are as follows:

Diagnoses	*No. of Cases*
Chronic subdeltoid bursitis	6
Ruptured disc (operated with spinal fusion)	4
Fractures of a single extremity	5
Multiple fractures	5
Multiple amputations	4
Compression fracture of spine	2
Severe sprains	2
Wringer hand	1
Stenosing tenosynovitis	2
Deranged knee cartilage	1
Hypertrophic arthritis of knee, spine, hip	2

The average age of the thirty-four patients, whose diagnoses appear above, is 47 years, and the average length of time from the date of their accident to the date of treatment at the Centre is seven months. Seven of the patients are now nearly ready to return to work. Four others will eventually need surgery. In all probability nine of the cases will have some residual loss of motion of which five, including two extensive amputations, will be unable to return to their regular work.

The above gives some idea of the type of cases treated and the results obtained to date at the Rehabilitation Centre. Our cases are not hand picked and any case which might be benefited is admitted for treatment.

In all of the above cases the diagnosis has been definite. No such diagnosis can be made in the acute back strain, and consequently none of these cases have been admitted as yet. However, in the near future we intend to attempt treatment of this condition.

The idea of rehabilitation of the injured workman is relatively new. Much has yet to be learned in the proper handling of these cases, particularly from the point of view of work therapy. However, though the Rehabilitation Centre is still in the experimental stage, we feel that it is of definite value.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACTS OF CONGRESS OF AUGUST 24, 1912, AND MARCH 3, 1933

of *Rhode Island Medical Journal*, published monthly at Providence, Rhode Island, for October, 1943.

State of Rhode Island } ss.
County of Providence }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Peter Pineo Chase, M.D., who, having been duly sworn according to law, deposes and says that he is the Editor-in-Chief of the *Rhode Island Medical Journal* and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, as amended by the Act of March 3, 1933, embodied in section 537, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Rhode Island Medical Society, 106 Francis Street, Providence, R. I.; Editor, Peter Pineo Chase, M.D., 106 Francis Street; Managing Editor, John E. Farrell, 106 Francis Street, Providence, R. I.

2. That the owner is Rhode Island Medical Society, 106 Francis Street.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock bonds, or other securities than as so stated by him.

PETER PINEO CHASE, M.D., *Editor-in-Chief*

Sworn to and subscribed before me this 14th day of October, 1943.

JOHN E. FARRELL

(My commission expires June 30, 1946.)

[SEAL.]

EMERGENCY MATERNITY AND INFANT CARE PROGRAM

Final report *of the Special Committee Authorized by the Council of the R. I. Medical Society to Study the Federal Emergency Maternity and Infant Care Program for Rhode Island. This report has been received and approved by the Council.*

At its September meeting, the Council of the Rhode Island Medical Society authorized the Chairman of the Committee on Maternal Health to appoint a committee to consult with Dr. Francis V. Corrigan (Medical Director of the Division of Maternal and Child Health of the Rhode Island Department of Health) in formulating a plan to put into effect the Emergency Maternity and Infant Care Program authorized by Congress under the Children's Bureau. The following physicians consented to serve on this committee:

Dr. John Helfrich, Westerly
Dr. Alfred Potter, Providence
Dr. John G. Walsh, Providence
Dr. Henri Gauthier, Woonsocket
Dr. John Kenney, Pawtucket
Dr. George Young, East Greenwich
Dr. Henry Utter, Providence
Dr. Wm. P. Buffum, Providence
Dr. James Callahan, Newport
Dr. E. S. Brackett, Providence, Chairman

The program in its essential features has been outlined by the Federal Bureau and forwarded to the Department of Health of the various states leaving to the States only administrative details such as the eligibility of hospitals, the agencies through which applications for benefits may be made, etc.

The Federal program contemplates (1) the payment of stipulated sums to hospitals and (2) payment of stipulated fees directly to physicians for maternity care to mothers and pediatric care to children under one year of age of men in the armed services. The program in brief outline is as follows:

Eligibility. The wives and children (under one year of age) of service men in the four lowest pay grades of the Army and corresponding grades in the Navy (including the Coast Guard and Marines) are eligible to receive benefits under this program. These four grades include all grades up to and including sergeants. The families of sergeants above the fourth pay grade are not eligible as their pay is often equal or more than that of some of the commissioned officers. In determining the eligibility of applicants for benefits no consideration is given to the financial status of the applicant.

Hospital Care. The State Board of Health, from funds made available by the Federal Children's Bureau under this program, will pay directly to hospitals their bills for ward care of eligible patients at a per diem equal to the per diem cost to the hospital. The patient must become a ward private or ward patient. She may not apply her government allowance as part payment for semi-private or private room service. If she chooses to be a semi-private or private patient she forfeits her right to a government allowance.

Eligibility. All hospitals in the state approved by the American College of Surgeons are eligible. No salaried employee of the hospital may receive any remuneration for medical care of a ward patient, such medical care being considered a part of the hospital service.

Medical Care. The Federal Government through the State Department of Health will pay specified sums directly to physicians for Maternity Care and Pediatric Care to wives and children under one year of age of service men in the four lowest grades. The physician accepting a patient under this plan must sign a statement that he will not accept any further payment for the care and the patient must pledge herself not to pay any fee in addition to the fee paid directly to the physician by the government. The physician accepting a patient under this program may not charge, or the patient pay, any additional fee for obstetrical or surgical operations or for the treatment of obstetrical or medical complications during pregnancy, labor or the puerperium. Provision is made for necessary consultations. The fee is all inclusive for obstetrical service for the period of her pregnancy, labor and puerperium (six weeks).

Similarly specified allowances are provided for pediatric care.

The patient may choose her own physician. Under the plan as proposed for the State of Rhode Island any registered physician who is a graduate of a Class A medical school is eligible to receive payment from the Federal fund.

A patient may choose to be delivered in her home. Provision is then made to pay the usual charge of a visiting nurse in addition to the payment to the doctor.

If she arranges to be delivered in a hospital her hospital bill as a ward patient will be paid and a stipulated sum may be paid to her physician for complete obstetrical care including antepartum visits, labor and postpartum care up to six weeks. As previously stated, if the patient chooses to enter the hospital as a semi-private or private patient she forfeits her right to have her hospital and physician's bills paid under this program.

The patient may choose any physician who has the privilege of practicing obstetrics or pediatrics in the hospital of her choice.

First Meeting of Committee

The first meeting of the committee was held September 29. Doctor Corrigan submitted a Rhode Island plan which, if approved by the Society, he proposed to submit to the Federal Children's Bureau for approval. After an explanation of the plan by Dr. Corrigan and a frank discussion of the plan by the committee the following conclusions were reached.

The committee recommended (1) approval by the Society of the objective of the plan. It was the sense of the committee that the government having taken into service to fight for our country the breadwinners of the family, it is under a moral obligation to provide for their families all the necessities of life, maternity and pediatric care being among them. (2) Approval by the Society of the payment directly to hospitals of the cost to hospitals of providing ward care for maternity and pediatric cases in the families of men in the armed services. (3) Approval, in principle, of the government making allowances under the proposed plan for medical care of maternity and pediatric cases. The committee believes that whether this program is put into effect or not, no wives or children of men in service need ever suffer in Rhode Island for lack of adequate medical service no matter how needy they might be. This has been true in peace times and certainly in these times of emergency the medical profession would not be likely to abandon all its honorable traditions of service to rich and poor alike.

The committee had several objections to the manner in which the proposed relief must be administered. These objections will be discussed later. The committee also criticised the plan as submitted because it failed to provide in adequate measure for medical and surgical consultations and treatment for intercurrent conditions which might need the specific knowledge and skill which only a specialist could possess.

Dr. Corrigan was requested to formulate a plan to meet the objections of the committee. This he did and submitted it to officials of the Children's Bureau who, very tactfully, made it quite plain, unofficially, that any plan that modified the benefits as prescribed by Congress would not be accepted.

Participation by Doctor Voluntary

At the second meeting of the committee on November 3rd, Dr. Corrigan submitted a third plan, already outlined, in regard to which the committee has the following observations to offer.

While it is opposed to many provisions of the plan it does not feel that the society should withhold its co-operation. No group in war time is justified in adopting an uncompromising attitude toward government measures. It believes the society should not make any recommendations as to the attitude of the individual members toward accepting a fixed fee paid to them directly by the government, but if they do accept such a fee the society would severely condemn any attempt on their part to circumvent the conditions under which the fee was accepted. It does not feel that any member is under any moral obligation to accept cases under this program. The refusal of an individual member to accept these cases would not cause any woman or child in Rhode Island to suffer from lack of adequate medical care. The patient is still at liberty to employ another doctor or to be treated in a hospital as a ward patient.

Objections Voiced by Committee

The committee feels that, having approved in principle the objective of this plan and having recommended that the medical profession co-operate in carrying it into execution, it should state its objections to some of its provisions.

It objects to what it considers too rigid bureaucratic control of funds allocated to the various states by the Federal Children's Bureau. State Departments of Health should be given a freer hand in adapting their methods to the needs of the territories which they serve.

continued on next page

It objects to the payment of funds directly to the doctor rather than to the patient to be spent at her discretion. The allowances for the support of the wives and children of service men are not hedged about by any such restrictions. Undoubtedly an occasional improvident patient would spend the allowance unwisely and her doctor's bill would not be paid, but it is no new experience for a doctor to have unpaid bills on his books. In any case, the doctor would be the only loser, for in Rhode Island no improvident patient need ever suffer for lack of maternity care or pediatric care for her baby. Lack of faith in people whom they are supposed to serve is characteristic of bureaucrats. The threat of financial loss to the medical profession is insignificant compared to the threat to the profession and public of bureaucratic control of the private practice of medicine implicit in these unnecessary restrictions.

It objects to the provision that limits allowances to ward patients. It does not consider the allowances under this program as a charity dole to the medically indigent but as a discharge of a moral obligation on a par with army pay and allowances for the support of the wives and children of service men. It can see no valid reason why, if a patient can afford to do so, she should not be allowed to add a few dollars to the government payment to the hospital and occupy a semi-private or private room. She could do so if she were a member of the Blue Cross or were insured in a commercial insurance company. This is another example of the bureaucratic control of medical practice.

It has the same objection to the provision which prevents a patient from coming to a financial arrangement mutually satisfactory to her and the physician of her choice, and compels her to promise that she will pay her physician no fee in addition to the government allowance and the physician to pledge himself not to accept any additional fee. It objects to the inflexible, government-dictated, fixed fee—a form of price fixing which even in the present emergency is unnecessary. The committee has no quarrel with the amount of the fee. Taking into account the government guarantee of payment in full and the fact that many patients who would benefit by the program would otherwise be unable to pay a doctor anything at all, it is not unlikely that the medical profession would profit financially by this arrangement. It should not without protest exchange its right to deal directly with its patients for a temporary financial advantage and further bureaucratic control of the practice of medicine. The committee believes that the government allowance should be paid directly to the patient and she should be free to make her own financial arrangements with the doctor of her choice.

Program Fraught With Political Implications

If the committee felt any assurance that this program was, as its name implies, merely an emergency measure and would be discontinued after the war, it might accept its objectionable features without protest as part of the economic dislocation inevitable in war time. But it has, it believes, good ground to fear that it is, over and above its immediate humanitarian objective, another move by a group of professional uplifters toward their ultimate goal of complete domination of the practice of medicine by the Federal Government. The more the practice of medicine is controlled by government the deeper it will get into politics. Control by government means control by politicians and bureaucrats. Cancer and tuberculosis and heart disease do not select their victims because of their political affiliations. A sick politician seldom chooses his physician because of his political faith, but too often when a salaried medical appointment is to be made the first question asked is not who is the best available man for the job, but who is the most available Republican or the most available Democrat, and the man who has the most powerful friends gets the job. However high-minded the political leaders at any particular time may be and however fortunate their appointments, in the long run the system inevitably tends to lower the standard of medical practice. The deeper the private practice of medicine becomes involved with government, the more rapid will be that deterioration. In no country in the world is the private practice of medicine more efficient than in America. This efficiency is in large measure due to the fact that government, heretofore, has in the main confined itself to its proper sphere (sanitary codes, drug control, sanitaria and hospitals for the indigent and the like) and has kept its hands off the private practice of medicine.

It is government interference in the relation between the physician and his private patient in the program under consideration which alarms the medical profession for it is convinced that government interference can have but one result—less efficient care of the sick.

MEDICAL AND SURGICAL TREATMENT OF VARICOSE VEINS, PULMONARY EMBOLI, AND GASTRIC AND DUODENAL ULCER

A Summary *by Anthony V. Migliaccio, M.D., Associate Surgeon, R. I. Hospital, of the Discussions at the November Meeting of the Providence Medical Association by Arthur W. Allen, M.D., Chief of East Surgical Service, and William B. Breed, M.D., Visiting Physician, Massachusetts General Hospital.*

On Monday, November 1, 1943, Dr. Arthur Allen, Surgical Chief at the Massachusetts General Hospital and Dr. William B. Breed, associate in medicine at the same hospital, provided us with a lot of food for thought in a question and answer program covering the subject of varicose veins, pulmonary emboli and the perennial problem of ulcer, both gastric and duodenal. It was brought out that the injection treatment of varicose veins at the Massachusetts General Outpatient provided an 80% failure. Because of this, dividing the great saphenous vein and its branches was tried with better results. This latter procedure was supplemented with injections at the time of the operation, but in their experience the sclerosing fluid rarely went beyond the lower thigh. Dr. Allen admitted that he had had no experience with the use of injecting fluid through a urethral catheter which had been inserted into the great saphenous and pushed down to the midthigh.

Because of the failure with his method of getting sclerosis below the knee, Dr. Allen has gone back in many cases to a stripping operation which is somewhat modified from the old technique. It was his opinion that sympathectomy was indicated in some of the cases of leg ulcers which had failed to respond to ligation and injection treatment, but he felt that sympathectomy for this condition is being done more often than it should be. On the question of varicose veins following phlebitis, it was felt that if after six months the deep circulation could be found not to be blocked that then ligation of the superficial veins could be carried out.

Dr. Breed felt that the use of heparin and dicouramin in the treatment of emboli was not all that it was supposed to be. He felt that the three or four day lag period which was present in the use of these drugs was of definite disadvantage. At the Massachusetts General it is customary for the medical man to tell the surgeon to ligate the femoral veins immediately whenever a diagnosis of pulmonary embolus has been made. It was Dr. Allen's opinion that the ligation of the femoral veins was a distinct improvement over the old methods of treating emboli. The diagnosis was suspected as soon as any patient showed a slight rise in temperature, pulse and respirations, and as soon as these changes were observed a close and careful study was made, and if it was felt that a thrombus existed, ligation was immediately carried out. This operation has not only improved the mortality figures but it has also shortened considerably the hospital stay of these patients. Following the ligation of the femoral vein it was the experience of the Massachusetts General group that even though the embolus extended beyond the point of ligature and could not be removed by the usual methods that not a single case of fatal emboli following ligation had occurred. The average hospital stay is approximately five to eight days and it is not unusual for patients to get out of bed on the day following operation.

During the discussion of peptic ulcers it was interesting to note the unusual amount of cooperation and coordination that existed between the medical and surgical consultants. Dr. Breed said that the audience would probably think that he was Dr. Allen's assistant from the way he spoke about the treatment. This was an interesting innovation especially to those surgeons in the audience who felt that the medical man in the past had been too slow in advocating surgery in his ulcer patients. He brought out the fact that close cooperation and immediate consultation with the surgeon is essential if the treatment of ulcer is to be improved.

The young patient with a bleeding ulcer can be treated medically with an extremely high percent of success. In the older patients, the decision of whether to treat surgically or medically is extremely difficult. If surgery is to be undertaken at all in a patient beyond 45, it should be carried out within the first 72 hours. After 72 hours the mortality rate makes it too hazardous to undertake. Location of the site of bleeding must be definitely

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WARTIME CIVILIAN MEDICAL CARE

Report *of Committee on Problems Due to the Shortage of Physicians. Elihu S. Wing, M.D., Chairman, Charles J. Ashworth, M.D., and Alfred L. Potter, M.D.*

With more than one fourth of all the medical doctors of Rhode Island in the armed forces, and more soon to enlist, the problem of civilian medical care is an extremely important one. There has been much concern expressed in some parts of the State relative to the availability of doctors to provide adequately for the protection of health on the home front.

Any discussion of the civilian medical care problem must be prefaced by a clear understanding of the fact that medical service for the armed forces is a priority that takes precedence over all other requirements. It is the one service for which there can be little or no compromise. We all expect, and even demand, that our men fighting on the war fronts all over the world shall have the benefits of the finest medical care available. The doctors of America have responded willingly to the call for military duty and at the present time there are approximately 50,000 of them in active service, in every land where American soldiers are stationed.

The voluntary enlistment by doctors from the very onset of the war probably affected the amount of medical service available in some parts of the country, but with the establishment of the national Procurement and Assignment Service under the War Manpower Commission, with a medical committee in each State, every effort has been made to balance the needs of the armed forces with the minimum requirements of the civilian population. Through this agency every doctor has been classified, not only as regards his age but more particularly as to whether he can be replaced in the community, or whether older doctors can absorb the additional work created by his enlistment.

With the war areas continuing to expand, and with battle engagements becoming increasingly more intense, the need for additional medical personnel by the armed forces is self evident to any citizen. This additional drain upon the roster of doctors still in civil practice is certain to be a cause for concern and even worry relative to the protection of civilian health. It is time that everyone recognize the seriousness of the situation and make every effort to safeguard his personal good health during the months ahead.

Medical care will continue to be available for the civilian population. However there is every reason to believe that in the winter ahead such care will be limited by factors beyond the control of all of us at the present time. Emergency and essential medical care for all who require it will be available, but additional service will depend in no small measure upon the physical ability of the doctors, many of whom are advanced in years, to meet the demands.

The situation in Rhode Island has been repeatedly checked by the Procurement and Assignment Service, the U. S. Public Health Service, and by the special committee of the Rhode Island Medical Society to study the problems resulting from a possible shortage of doctors. The number of medical doctors in the State, exclusive of those employed as full time staff members of hospitals and institutions, totals 626 in active practice, according to the best figures available to our committee. Of this number 398 range in age from 45 to more than 80 years, while 223 are aged up to 45 years. Many of the later group are now listed as available for military duty and will undoubtedly volunteer with the armed forces in the near future.

Nationally there have been statements to the effect that the ratio of one doctor to every 1500 population is a safe one for the protection of civilian health. If such a yardstick were applied to Rhode Island today we would be more than adequately protected, with an average on the present figures of one doctor to approximately every 1140 persons.

However, there are many reasons why this statistical gauge may, in part, be disregarded here. In the first place the 626 doctors in active practice include 115 who are certified specialists in particular phases of medicine and surgery, and therefore they must be considered as available for limited fields of work only, although, no doubt, in an emergency they would be ready to do general practice. Remov-

ing this group from our total would still give us a presumably safe average of one doctor in general practice to every 1400 persons in the State.

But even this figure cannot be taken at face value, for the distribution of doctors is not comparable to the distribution of the entire population. Thus we can strike an average of one doctor to every 1000 persons in the city of Providence, one to every 2600 persons in East Providence, and Cranston, one to every 1400 in Pawtucket, and one to every 3600 in Central Falls. Yet there is no real shortage in any of these communities, for their geographical proximity, together with modern rapid transit, has made the doctor in Providence as available to the people of Cranston or East Providence as he is to citizens in parts of Providence. The same situation holds for Pawtucket and Central Falls, and for many other communities of the State that are adjacent to larger cities or towns.

There are other factors, too, which must be considered. The personal choice of the individual in the selection of his physician results in certain doctors carrying more work than some of their colleagues. The age and physical ability of other doctors force them to limit their practice and to eliminate travel as much as possible. The additional strain created by the task of coping with all the demands for medical attention while more than 200 Rhode Island doctors are away on military service has resulted in excessive fatigue and sometimes illness for many doctors, necessitating that they concentrate on emergency and essential needs.

Therefore we cannot say that a numerical ratio is any criterion that everyone is going to get medical attention at any time he may desire it. Rather, we can only assure the people of Rhode Island that the medical profession stands ready to do all in its physical power to meet the necessary requirements of the civilian population during this trying period. There will be times when a doctor cannot be reached promptly. We can only ask that everyone make an earnest effort to safeguard his own personal health at all times, and also that every citizen endeavor to conserve the time and the energy of the doctors that they may be able to cope with emergency and really essential demands.

In January the Civilian War Services of the State Council of Defense will launch its Keep Well Crusade which has the endorsement of the Rhode Island Medical Society. Pamphlets are to be distributed giving suggestions relative to ways to help the doctor during the war emergency, and we are sure that if these suggestions are adopted generally, not only will the physician's burden be eased but the health of the public will be better protected in the difficult days ahead.

DISTRIBUTION OF DOCTORS FOR CIVILIAN CARE

(As of December 1, 1943)

	Total M.D.'s Now In Practice	*Active M.D.'s Age Over 45*	*Age Under 45*	*M.D.'s Not In Practice*
BLACKSTONE VALLEY				
Central Falls	7	5	2	
Lonsdale	1	1		
Pawtucket	55**	33	20	4
Saylesville	1		1	
Valley Falls	1	1		
BRISTOL COUNTY				
Barrington	1	1		1
Bristol	5	2	3	1
Warren	5	4	1	
KENT COUNTY				
East Greenwich	3	2	1	
Lakewood	2	2		
Norwood	1		1	
Warwick	5	2	3	1
West Warwick	14	7	7	
NEWPORT COUNTY				
Adamsville	2	2		
Block Island	1	1		
Jamestown	1		1	
Little Compton	2	2		2
Newport (City)	24	14	10	3
PROVIDENCE AREA				
Cranston	18**	10	7	2
East Providence	12	7	5	
Providence (City)	371	245	126	10
Rural	11	7	4	1
WASHINGTON COUNTY				
Rural	18	10	8	2
Westerly	19*	14	5	
WOONSOCKET DISTRICT				
Harrisville	1	1		
Pascoag	3	3		
Manville	2	2		
Slatersville	1		1	
Wallum Lake	2	1	1	
Woonsocket (City)	37**	19	16	1
TOTALS	626***	398	223	28

*Age of one doctor not known.
**Age of two doctors not known.
***Includes 5 doctors—age unknown.

VARICOSE VEINS, PULMONARY EMBOLI, Gastric and Duodenal Ulcer

continued from page 293

established even if a fluoroscopic examination must be undertaken before surgery is considered. Once it has been decided that the bleeding is from an ulcer and that surgery is necessary, then gastric resection is the procedure of choice. The blood pressure should be above 100 before surgery is undertaken. In a patient in whom a vessel has been eroded by the ulcer, recovery from transfusion is less likely to occur. Multiple transfusions are necessary both in the medical and surgical treatment of the bleeding ulcer. In those cases where bleeding stops, Dr. Breed believes in feeding them as soon as the patient is hungry. Dr. Breed is also of the opinion that a middle course between starvation and the Mullengrath treatment is the proper course in the treatment of bleeding ulcers. Antacids in ulcers are not good, bicarbonate should not be used, aluminum should be used only for emergency rations and the time table in feeding is much more important than the type of food.

The treatment of gastric ulcer is definitely one of surgery. Fourteen percent of the resected cases invariably show Ca. and here the medical treatment is not as successful as it is of duodenal ulcer. Moreover, gastrectomy in the presence of gastric ulcer is much safer than it is in cases of duodenal ulcer, as in these cases the duodenum is perfectly normal. It is the poor closure of the diseased duodenal stump that causes 50 percent of the postoperative trouble in gastrectomies. The patient with duodenal ulcer should be submitted to surgery in all acute conditaions, such as perforation. He should also be submitted to surgery whenever he has become tired of his pain and when the medical treatment has failed after several honest attempts at cure. Gastroenterostomy should never be performed except in the presence of complications. Gastrectomy is by far the best treatment that we have today for ulcer. The incidence of ulcers of the stoma following this operation is less than 1%. Dr. Allen even refuses to do a gastroenterostomy in the old patient with obstruction and low acidity because in his experience the results have been very poor, whereas, gastrectomy has always proved satisfactory.

Dr. Allen prefers to use a posterior short-loop Hoffmeister type of operation. The anticolic is rarely used on his service. He claims that the anticolic is easier to perform, that it takes less time but that it is much more apt to get into trouble because of the chances of adhesions of the anastomosis to the undersurface of the abdominal scar. He also believes that there is more malfunction in the anticolic group than in the posterior type.

Dr. Allen has drained the duodenal stump in approximately 20 cases but he feels that it is unnecessary. He also prefers to use No. 30 cotton for suturing and No. 60 cotton for ties.

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The RHODE ISLAND MEDICAL JOURNAL

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THE CURATIVE CENTRE

The General Assembly at its last session enacted legislation establishing a special curative centre fund the purposes of which are stated in the law as follows:

"To provide a suitable structure for the housing of the curative centre."

"To furnish said structure with necessary equipment for the rendering of physical therapy, psychotherapy, and occupational therapy."

"To provide for the payment of all salaries of personnel necessary for the operation of the centre."

"To provide funds to pay all other expenses for the carrying out of the above purposes. The director of labor shall purchase all necessary equipment . . . after consultation with the medical director and with the advice, consent and approval of the advisory board."

The Advisory Board provided in the law is to consist of the director of labor, the chief of the division of workmen's compensation and three medical men to be appointed by the director of labor WITH THE ADVICE AND CONSENT OF THE COUNCIL OF THE RHODE ISLAND MEDICAL SOCIETY.

Here is the status of this program as it appears to us today, some seven months after the Governor signed the act to make it the law.

The Medical Advisory Board has not been appointed, and no names of medical men have been submitted to the Council of the Rhode Island Medical Society. The medical director, the key man in the entire program, as Dr. Aitken has so pointedly indicated in the article in this issue relative to the Rehabilitation Centre of the Liberty Mutual Insurance Company in Boston, has yet to be recommended to the Council of the Rhode Island Medical Society whose advice, consent and approval is required by law prior to his appointment.

But approximately three-fourths of the fund accumulated this year has already been expended for a 35-room residence, leaving, according to the latest public announcement, less than $14,000 with which to purchase equipment, hire medical, technical and clerical personnel, and meet the ordinary expenses of building maintenance! It is reported that the State has already taken steps to get priorities for the purchase of equipment, a step that undoubetdly is necessary in these days of limited production, but it is interesting to note that the law states that purchases of equipment are to be made *after* consultation with the medical director and with the advice, consent and approval of the advisory board. Before seeking priorities it would appear advisable to determine exactly what equipment is to be approved for purchase.

The public announcement of the purchase of the estate to house the Curative Centre also contained alleged statements that the residence would be furnished with the equipment of the individual tradesmen who will use the centre, and will cover all branches of the building trades. The statement was also made that it was estimated that from 40 to 50 patients a day would be treated once the centre is established, and the handling of up to 100 cases a day could be effected by the purchase of additional equipment.

After reading the excellent study of the Boston rehabilitation center in this issue of the JOURNAL, and after a visit to that centre, we are a bit confused as to the program of rehabilitation work the local authorities indicate for the curative centre here. We sincerely doubt that individual equipment is either necessary, or possible, to cover all branches of the building trades. Rather we believe the centre is to aim at the fundamental basic physical and occupational activities, such as are already carried on at the Rhode Island Hospital and at the Bureau for the Handicapped, as the means to speed the return of the patient to work, and preferably to his own occupation. When we note that the centre established by the Liberty Mutual Insurance Company is available to far more workers throughout New England than there are in our State alone, and that in four month's time only 64 cases were admitted for treatment and only 34 are now in attendance, we are completely at a loss to understand the 40 to 50 patients *a day* expected at the Rhode Island Curative Centre when it is opened.

The medical profession of Rhode Island has always been willing to assist in any program which will aid in the restoration of good health to the sick and the injured. It desires that the Centre be given full opportunity to prove its value to the industrial workers of the State, but it recognizes that the success of the program hinges far more on the medical and technical supervision of the patients than on the location of the building wherein the treatment is to be given. There should be no further delay in the appointment of the medical director and the advisory board.

THE DOCTOR SHORTAGE

Our country needs immediately more doctors for the armed services, as casualties on the war front are increasing rapidly. The 50,000 doctors in service (nearly a third of the country's physicians) are scattered all over the world. There are in this country 600 Service Hospitals, including scores of over 1000 beds, occupied in part by service men from overseas.

Rhode Island has a doctor shortage—as do most States of the Union—though we are amongst the more fortunate, since our small size and compact population give better access to medical care than is the case in the larger States.

Where would our privileged American life now be with its great institutions and high ideals had not thousands of our doctors and civilians volunteered for its protection? These men and women have left their jobs, homes and families, and are risking life and health that America may continue to enjoy the privilege of religious liberty and the pursuit of happiness. Surely our patriotism must equal theirs.

With this urgent need existing by the military forces for more doctors many, especially in the towns and cities, are still classified as "A"—available. Whereas withdrawal of these men from their home communities entails sacrifice both by themselves and the civilian population, it is a sacrifice which all should freely offer in so sacred and just a cause.

Our citizens, most of whom now have near and dear ones in the service, may of right ask that their boys' health and well-being be properly cared for, an impossibility except with sufficient medical personnel. These same citizens will place "the boys" first, "themselves" last, in this matter of proper care.

The recent Procurement and Assignment meeting under the auspices of the Rhode Island Medical Society, and the attendant interviews with a majority of those still available, proved that a considerable number volunteered to apply for a commission, while others declared they would probably do so. The P and A Service, which constantly emphasizes its function as a body to encourage "voluntary" offers of service, is inclined to believe that further such offers will follow immediately. The need is not next year, but today.

In 1942 the Rhode Island quota for doctors was met exactly 100%. In 1943 the quota is far short of completion.

Patriotism led those into service in 1942. A like patriotism, we hope, will lead others to volunteer until the 1943 quota is filled.

IT'S YOUR JOURNAL

With this issue the RHODE ISLAND MEDICAL JOURNAL completes its twenty-sixth volume. The occasion takes on added significance in view of the

recent expansion which has warranted much favorable comment, and which presages a future development that will go far towards making it one of the outstanding journals.

By national authorities your JOURNAL has been characterized as the finest medical publication from the viewpoint of typography and format. That the contents are far above the average is fully evidenced by the fact that they have been subject to reprint and review in other publications. For example, the excellent paper by Dr. Place which appeared in the August issue has been summarized and published in *The Trained Nurse and Hospital Review;* the article on "The Luxury of Social Insurance" in the September issue has been widely publicized by insurance groups, and has recently been reprinted in *The Weekly Underwriter,* one of the leading insurance publications with national distribution; and the exceptionally fine report on "Burns" in the October issue has been reprinted by the National Fire Protection Association for nationwide reading.

Some of the editorials have been copied in other medical publications, and last month's lead editorial, while misinterpreted in some circles, has provoked an open discussion of the medical aspects of the State sickness insurance program which will go far towards a better evaluation of the plan.

The development of departments within the JOURNAL for the purpose of more fully informing the members of the various activities and problems of the Society has involved much detail work. The assistance of members is sought to further these efforts and to make your JOURNAL the best in the country.

E M I C PROGRAM

Every member of the Society should read carefully the report of the special committee authorized by the Council of the Society to study the emergency maternity and infant care program created by the Federal Children's Bureau of the Labor Department, and administered locally through the Division of Maternal and Child Health of the State Health Department.

The program has been the subject of debate the length of the land. Its adoption by state departments of health has been construed wrongly to constitute complete endorsement by the medical profession of the respective states, whereas in truth the profession has had no say whatever in the shaping of the policies by which the assistance is granted.

In spite of the nobility of the purpose—a purpose which the medical profession by and large was already meeting without placing any additional financial burden on the families of service men—the program is a challenge to every doctor. It places the control of a local plan of medical service under a federal supervision which admits of little alteration to meet local conditions. It denies to the patient a cash allowance to assist her to meet her requirements as she desires, even to the extent of forbidding semi-private or private care in the hospital when such accommodation is within her budget. It sets a fixed fee for the complete care and denies the existence of, and discourages the attempt at, better than ordinary obstetrical service, and it implies the possibility that this program will be the forerunner of other similar projects in the months ahead.

What is not generally known is that the program is not the original creation of Congress acting as the representatives of the people. It stems from the Children's Bureau itself which made $380,000 available by administrative action. The 77th Congress subsequently failed to enact as part of the appropriation bill a $750,000 request of the President, and as a result the Children's Bureau continued to make allotments administratively.

Again, in 1943, when the President asked for $1,200,000 to carry on the EMIC program the House refused because it felt that Congress had never authorized the program in the first place. The Senate amended the appropriation bill, however, to include the amount, and the House finally conceded. This money lasted but three months and a second appropriation of $4,400,000 was made, but that too lasted for only a short time. Last September a supplemental appropriation bill was enacted to provide $18,600,000 to continue the expansion of the work.

If, as the special investigating committee of the Society has pointed out, there was any assurance that this program is as its name implies, merely an emergency measure which will be discontinued after the war, the present objectionable features might be tolerated. But the major issue appears to resolve itself into the question of determining how readily a program that has increased more than fifteenfold in cash expense in less than a year can be not merely curtailed but eliminated at the end of the war period.

THE MEDICAL LIBRARY

The Medical Library is more than a mere storehouse for the records of a great profession. It is

probably the most important single service offered to the Profession, for its rich materials constitute a treasure that offers unlimited possibilities to the physician who knows how to make full use of it.

Many of our members undoubtedly have little idea of the help and guidance that is available through our exceptional staff of Miss Dickerman and Miss Moffitt whose long experience in medical library work assures the busy doctor aid that can readily be valued in terms of accuracy and time. The thought and labor involved in making available on short notice to any member the latest data on any medical subject is probably never realized or fully understood by the doctor.

Every new book acquired, by purchase or gift, is carefully examined and indexed before it takes its place on the shelves with the more than 35,000 volumes now stored at the Library. More than 150 medical journals are collated each month, and the outstanding ones are bound for permanent file. All publications are indexed promptly in order to make available the newest material on any subject on short notice.

Thus, when a doctor cannot spare the time to do his own searching for materials on the problems which interest him, a telephone call to the Library results in complete reference service. All available literature on the particular subject is surveyed and books and articles are selected and marked for his ready reference. Thereby his time and energy are conserved when he arrives at the Library.

For members who are outside the city, and also for the medical personnel at the military installations in the State, the Library offers a liberal mailing service. Requests directed to the librarian receive prompt attention, and each month now the JOURNAL publishes the newest volumes added to the files.

The Medical Library, exclusively owned and maintained by the medical profession of Rhode Island, is one of the finest libraries in the country. It is capable of many services to the individual doctor. Are you utilizing its facilities to the fullest advantage?

CANCER PREVENTION CLINICS

We are told that doctors in China are paid for keeping their patients well and not for treating them when sick.

The custom has considerable merit, in so far at least as it forces the Doctor to be on the lookout for those early symptoms that treated promptly may prevent the development of serious illness.

Our own people are so prone to adopt a laissez faire attitude until forced by evident symptoms to seek relief that the Chinese practice could never be popular here. But we are beginning to approximate it by urging upon our public the wisdom of annual or even semi-annual health examinations.

This is particularly true in the field of cancer where the American Society for the Control of Cancer asks the members of its Women's Field Army to be examined thoroughly at least once a year. Now we want to widen the field of these examinations by establishing what are known as "Cancer Prevention Clinics."

One of the last official acts of our late beloved President, Dr. Charles F. Gormly, was to ask the approval of the members of the Rhode Island Medical Society for the establishment of such Clinics in our midst.

Since this approval was given, a few words explaining what they are and what they are expected to accomplish may not be amiss.

The idea seems to have originated with Dr. Catherine Macfarlane of Philadelphia who established the first "Cancer Prevention Clinic" in 1938. Twelve hundred enrolled at the start but only 955 have continued for this five year period.

The establishment of this first Clinic has been followed by that of two others, one in New York, the Strang Cancer Prevention Clinic, housed in the Memorial Hospital, and more recently one organized by the Chicago Cancer Committee. These are essentially free Clinics, although those who are able pay five (5) dollars on admission to the Clinic.

The first examination includes a Wasserman, a blood count, the usual routine of heart, lungs, breasts, abdomen, pelvis and rectum and any special examination deemed necessary. If any symptoms of any disease are found the patient is referred to her own Doctor if she has one, otherwise she is sent to the proper Clinic in some hospital. Examinations are repeated twice a year and careful records are kept of all findings.

The three Clinics so far established are for women only, but the wisdom of enlarging their scope to include men is perfectly apparent. Perhaps the name might be changed to "Disease Prevention Clinic".

It is easy to visualize the amount of valuable medical statistics that would be accumulated if several such Clinics could be formed in various parts of the State.

To be successful the Clinics must have the cooperation of our medical men. On the other hand

there is no doubt that the Clinics will be a distinct help to medical practice in general and to the general practitioner in particular. Furthermore, if the movement is encouraged and the habit of regular examinations grows, there is no question but that we will have taken another important step along the road of "Preventive Medicine".

THE DOCTOR'S RESPONSIBILITY

After a personal visit to Rhode Island by one of its editors to study at first hand the operation of the Rhode Island Cash Sickness Act, *Survey Midmonthly*, a national publication, reports in its December issue about the program under the title "Money While You're Sick". In view of the criticisms levelled at the RHODE ISLAND MEDICAL JOURNAL for its editorial inquiry last month regarding the medical administration of the act, we note the following interesting comment made in the *Survey Midmonthly* article:

". . . . . Rhode Island physicians undoubtedly have some real grievances. It is not very flattering to prestige to have signed a form asking for continuance of benefits only to have the patient called in for examination by another doctor. Moreover, though the family doctor's decision to back a patient's claim for further benefits may be based on his knowledge of the patient's total physical condition, the board's examiners are concerned only with the patient's progress in overcoming the particular illness mentioned in the original application.

"In many ways the family doctor is actually the scapegoat of the program. If his patient has a tendency to malinger, he is faced with a dilemma of signing a claim against his own better judgment or losing a patient forever. On the other hand, though the law has been interpreted to mean that benefits are payable only to those unable to work, a doctor may find that his patient, though able to perform *some* work, is not yet well enough for the job he was on when he fell ill. In such instances, if continued benefits are disallowed, the patient is apt to go back to his old job before he is in condition for it, thus risking a physical relapse."

NEW ENGLAND HERITAGE

The action of the medical societies of New England in uniting for a discussion of the legislation proposing a federal system of medical and hospitalization benefits, and thereafter issuing a concise, clear-cut, critical statement of the problem, indicates a healthy expansion of the old New England principle of holding a town meeting to appraise fairly an important problem.

The statement itself is a document that warrants the attention of every citizen. It makes no compromise with the forces who would revolutionize the habits of the people of this area in an experiment that is far from sound. It is not merely a negative attitude regarding the proposed legislation. Instead it takes a definite stand in favor of free enterprise, the adoption of the insurance principle, and the value of cooperative effort between the Profession and government authorities for the solution of the health problems of the people. Significantly it strikes at the root of much of the trouble concerning the distribution of medical care, and it offers a solution which it believes in keeping with the thinking of the New England people.

The settlers of this part of the country were a healthy body of people, well-fitted to endure the privations and hardships of the wilderness, and at the same time well qualified to care for one another in the stress of ordinary family sickness. That heritage of self-reliance for the healthy and full assistance to the sick has never been lost.

However, the heritages of New England are not provincial. They have been carried to every part of the country to which settlers departed from here. Therefore we are sure that the statement of our medical societies at this time will strike a responsive chord with the people of every state.

MILITARY ANNOUNCEMENTS

ASSIGNMENTS

LIEUT. WERNER SEGALL, MC, Tilton General Hospital, Fort Dix, New Jersey

TRANSFERS

CAPT. PASQUALE J. CELESTINO, MC, 0461483, APO 85, Fort Dix, New Jersey

MAJOR J. A. DAILEY, MC, 0324751, Cushing General Hospital, Framingham, Massachusetts.

CAPT. ROBERT DREW, MC, 103rd F. A. Med. Det., Camp Blanding, Florida.

LIEUT. (j.g.) WALTER R. DURKIN, MC, USNR, U. S. Naval Training Station, Medical Department, Building 109, Great Lakes, Illinois.

LIEUT. ROBERT L. FARRELL, MC, 63rd Inf. Division, Camp Blanding, Florida.

LT. COMMANDER JOHN D. HUBBARD, MC, USNR, Navy 231, c/o Fleet P. O., New York, N. Y.

MAJOR HUGH E. KIENE, MC, O-469150, 96th General Hospital, Camp Maxey, Texas

CAPT. LOUIS D. LIPPITT, MC, O-1696239, APO 4950, c/o Postmaster, New York, N. Y.

MAJOR RALPH D. RICHARDSON, MC, 1696223, APO 4716, c/o Postmaster, New York, N. Y.

LIEUT. FREDERICK RILEY, MC, Post of Medical Officer, V-12, Brown University, Providence, R. I.

CAPT. W. T. VAN HUYSEN, MC, 0470909, APO 4916, c/o Postmaster, New York, N. Y.

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CORPORATION

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The Rhode Island Society of Industrial

Physicians and Surgeons and

The Rhode Island Industrial Nurses' Club

for their meeting to be held in the

Fiberglas Plant in Ashton, Rhode Island

on Tuesday, December 21, 1943

at 9:30 P.M.

FIBERGLAS

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INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
Charles L. Farrell, M.D., Chairman; Herbert E. Harris, M.D.; Stanley D. Davies, M.D.; Michael H. Sullivan, M.D.; William P. Buffum, M.D.

WOMEN IN INDUSTRY

EVER SINCE the war began women have entered industry in increasing numbers and there is no indication that there will be a lessening of women in industry, rather the reverse is true.

The employment of women workers presents distinct problems different from those involved with male employees. The industrial physician should give important consideration to the limitations of the female employee's ability. Women are more susceptible than men to fatigue. In a joint statement signed by representatives of eight government agencies, it has recommended (for both men and women) an eight hour day and a forty-eight hour week approximate the best working schedule. One day of rest for the individual in approximately every seven was stated the universal rule. In general it may be stated that working hours for women should be five hours fewer than the maximum for men. Women are ill more frequently than are men. A survey by the National Institute of Health in the winter of 1935 and 1936 included a study of the disability of some two hundred eighty thousand white persons in eight cities. The rate of illness in women from 15 to 64 years of age was about twenty-eight per one thousand in contrast to twenty-two per male workers. Women experienced a higher sickness rate than men in each age group.

It has been fully proven that women are more susceptible to certain industrial poisons than men. Dr. Alice Hamilton states that young women seem to be particularly susceptible to poisons which attack the nervous system. It is also well known that pregnancy may aggravate and accelerate industrial poisoning. Women machine operators seem to be more prone to oil dermatitis.

Careful Selection of Workers Necessary

The above should indicate the need for careful selection of the woman worker to fill the hazardous job. The proper control of industrial hazards will go far toward eliminating occupational diseases of women in industry. Night work for women is not recommended but if it is imperative that women be employed on the night shift certain precautions should be taken. First, make sure the individual is able to work on the night shift. No employee should work on the night shift if there is a history of anemia, respiratory disease, digestive disease or nervous disorder. Women with home responsibilities should not work on the night shift except as an emergency. Young girls should not be placed on the night shift as loss of regular sleep is more serious for young workers. If it is necessary to employ women on the night shift effective health supervision should be instituted. Such workers should be instructed to spend at least seven or preferably eight hours of continuous rest in bed, exercise in the open air, reporting at once to the Medical Department of any disturbances of health.

The Problem of Pregnancy

The most important problem which relates solely to women is pregnancy. Any plant employing women should give this subject serious consideration and a definite policy should be formed regarding it. Pregnant women should be known to the doctor and the nurse in the plant and should be required to see their physicians at regular intervals for prenatal check-up. This is distinctly not a plant

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December 21 at Ashton

An innovation in medical meetings will be inaugurated on Tuesday, December 21, when the Industrial Physicians and Surgeons Society, and the Industrial Nurses Club, will meet at the Ashton, R. I. plant of the Owens-Corning Fiberglas Corporation. The meeting is scheduled for 9:30 P. M., and it will be open to any physician in Rhode Island. Doctors are urged to form groups for the travel to Ashton.

After a tour of the plant to view at first hand industrial health procedures adopted by this outstanding corporation, the groups will conduct a brief business meeting, and will also hear a talk by an out of state authority on industrial medicine.



"Always tired" is a common enough complaint, but when accompanied by markedly low resistance to infections, low muscular tone and vascular weakness, by mental apathy and depression, the cause may be adrenal cortical insufficiency.

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DISTRICT SOCIETY REPORTS

PAWTUCKET

The monthly meeting of the Pawtucket Medical Society was held in the Nurses' Auditorium of the Memorial Hospital November 18, 1943. There was a change made in the constitution of the society to the effect that all new members must also be members of the state society. After a short business meeting the guest speaker, Dr. Herman C. Pitts, Providence, gave an interesting address on the Medical Aspects of the Wagner-Murray Bill. He brought out several points which showed the disadvantages of the plan in regard to the patient and to the physician, and urged the members of the profession to bring these factors to the attention of the people.

Dr. John F. Kenney addressed the Rhode Island Laboratory Technicians' Club on November 17, on "The Practical Applications of Liver Function Tests." Dr. E. W. Benjamin presented a paper on "The Physiology of the Graham Dye Test and the X-ray Studies of the Common and Hepatic Ducts in the Operating Room and in Post-Operative Studies."

Lt. Edward Foster, Army Flight Surgeon, visited old friends in Pawtucket prior to his transfer to oversea duty.

MARY ELAINE J. ROHR, M.D.

PROVIDENCE

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, November 1, 1943.

The Association approved of recommendations made by the Executive Committee that the balance of the Blood Transfusion Bureau Fund be transferred to the Association account and that there be added to it to make a total of $750 with which a War Bond shall be purchased in the name of the Association.

The Association also approved of changes in the By-Laws in keeping with the recommendations of the House of Delegates of the State Medical Society to provide for joint membership in the district and State Society at the time of initial application. These By-Law changes were as follows:

Proposed Amendments to the By-Laws

ARTICLE II. MEMBERS

Section 1. *Eligibility*

Any physician who, under the Constitution of this Association is eligible, may apply for membership in the Association *and also in the Rhode Island Medical Society,* and upon the affirmative vote of three-fourths of the members present at a regular meeting, shall be declared elected. Membership shall be granted in accordance with the classifications defined in these By-Laws, *and in the By-Laws of the Rhode Island Medical Society. Upon the election of a member the Secretary shall notify the Secretary of the R. I. M. S. and shall also allocate the proportionate share of the deposit made by the applicant for his assessment to the R. I. M. S.*

ARTICLE III. MEMBERSHIP

Section 1. *Mode of Election*

Applications for membership shall be made in writing to the Secretary and must be endorsed by two active members of the Association, and must be accompanied by a deposit of the amount of the annual dues of this Association *and of the Rhode Island Medical Society,* which deposit shall be returned if the applicant is rejected. The Secretary

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Capt. C. J. Riley Wins Decoration

Too late for the last issue of the JOURNAL was the announcement from the headquarters of the European Theatre of Operations of the award of the Soldiers' Medal for heroism to Captain Clarence J. Riley, MC, of Providence. Details relative to the award were not announced.

He is attached to the Army Air Forces stationed in Iceland, and his action which resulted in the medal award took place on August 5. He enlisted for military service a year ago and following the completion of training as a flight surgeon at Drew Field in Florida he went overseas last June.

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PROVIDENCE MEDICAL REPORT

continued from page 305

shall refer each application to the Executive Committee which shall report favorably on it at the next regular meeting, or as soon thereafter as may be, or adversely to the applicant.

Section 11. *Forfeiture of Membership or Expulsion from State Society*

Any member who shall forfeit membership in, or be expelled from, the Rhode Island Medical Society shall automatically forfeit membership in this Association at the same time.

Dr. Alphonse R. Cardi now serving with the Armed Forces of the United States was unanimously elected to active membership in the Association.

The President announced the appointment of Dr. John C. Ham to serve as chairman of the Committee on Tuberculosis to succeed Dr. U. E. Zambarano who had resigned.

The scientific program consisted of a round table discussion of the medical and surgical treatment of varicose veins, phlebitis, pulmonary emboli, bleeding and chronic duodenal and gastric ulcers which was presented by Drs. Arthur Allen, Chief of East Surgical Service, Massachusetts General Hospital, and William B. Breed, Visiting Physician, Massachusetts General Hospital. As part of the program Dr. Allen presented a motion picture in color of femoral ligation. The program was excellently presented and it provoked much general discussion by the members.

FRANK W. DIMMITT, M.D.,
Secretary

WOONSOCKET

A dinner meeting of the Woonsocket Medical Society was held at the St. James Hotel on Wednesday, November 17.

Guests at the meeting included officers of the State Medical Society who participated in an open discussion of the program of reorganization of the State organization. Among those present to address the gathering were Dr. Elihu S. Wing, President-elect of the State Society; Dr. Roland Hammond, former President; Dr. William P. Buffum, Secretary; Dr. Charles J. Ashworth, Assistant Treasurer; and Mr. John E. Farrell, Executive Secretary.

Dr. Guyon G. Dupre, president of the Woonsocket Medical Society, presided at the meeting, and introduced the out of town guests who answered in detail the various questions raised relative to the activities of the State Medical Society. Following the discussion it was moved that an amendment be adopted to the district society bylaws to provide that every member in good standing of the Woonsocket Medical Society be required to also apply for Fellowship in the Rhode Island Medical Society.

THOMAS J. LALOR, M.D.,
Secretary

NEWPORT

Construction was started on September 1 at Newport Hospital on a second story to be built over the present surgery, and on certain alterations to the present administration building to increase the size of the dining rooms, kitchens, and offices. The project has been initiated as the result of a survey by Newport and federal officials which was begun two years ago to determine whether the hospital had sufficient facilities to meet a sudden catastrophic incident, such as a bombing, which would necessitate care for many injured patients.

Original plans called for an estimated expenditure of more than four hundred thousand dollars to provide the needed facilities, but these plans were rejected by the government, and the project curtailed to provide the construction noted above for which a federal grant of $121,000 was made. It is hoped that upon the completion of the present addition the original plan to build a second story over the men's medical and surgical ward to house approximately 40 extra patients may be realized by additional appropriations.

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FROM THE SECRETARY'S DESK

WILLIAM P. BUFFUM, M.D.

122 Waterman Street Providence

WAR MEETING

A special meeting of the Society was called by the President for Friday, November 26, at the Medical Library. The purpose of the meeting was to review the work of the medical profession in service with the armed forces, and to answer some of the vexing problems relative to the enlistment of additional physicians from Rhode Island for military duty.

Speakers who addressed a sizeable gathering of doctors were Dr. Paul Barton, assistant executive officer of the National Procurement and Assignment Service; Major Norman Harrison, MC, who saw service in the battles of the South Pacific area and who is now stationed at Fort Devens; Lieut. Comdr. Walter E. Garry, MC, USNR, who also had more than 18 months of duty in the Pacific; and Lieut. Thomas Crahan, MC, USPHS.

Particular tribute was paid to Rhode Island for the splendid response that has been made to the appeal for doctors to serve with the military forces, and the contribution of this State was characterized as "one of the finest in the nation."

DR. REUBEN C. BATES HONORED

At a recent meeting of the American Association of Medical Milk Commissions Dr. Reuben C. Bates, of Providence, was elected one of the twelve members of the Governing Council, to serve for a 5 year term. Dr. Bates, for many years secretary of the Medical Milk Commission of the Providence Medical Association, thus becomes New England's representative on the national association's governing body.

INCOME TAX DATA

Members of the Society are reminded that income tax forms are available at the executive office. On or before December 15, the September 15th declaration must be corrected, if necessary, to avoid penalties, and the balance of the 1943 tax as estimated must be paid. Next March it will be necessary to file a complete 1943 return and pay any tax outstanding, and at the same time to file the 1944 declaration and pay one-half. You must also, in March, pay one-half of your unforgiven tax.

Dues paid to the Society are deductible from your income tax.

FELLOWSHIP ROSTER INCREASED

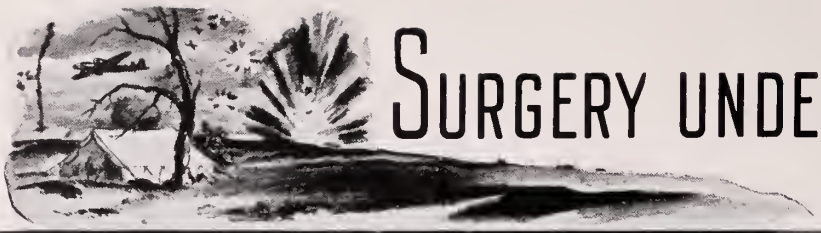
The highest roster of Fellows in the history of the Society has been reached as the result of the recent membership drive, with the total membership now numbering 673. Fellows whose applications have been approved within the past month include the following:

Drs. Robert H. Breslin, Alphonse R. Cardi, Joseph Castronovo, Benedict Chapas, George F. Creamer, John J. Donnelly, Richard H. Dowling, Walter R. Durkin, Bernardino Ferrara, Stephen J. Fortunato, Carl A. Gross, Howard Keefe, Wallace Lisbon, Alan E. O'Donnell, Anthony Romano, George R. Ronne, Paul Rozzero, Giovanni Senerchia, and Arthur O. Trottier.

SCIENTIFIC EXHIBITS FOR AMA SESSION

The Scientific Exhibit at the Chicago Session of the American Medical Association, June 12 to 16, 1944, will be held at the Palmer House. Exhibits will cover all phases of medicine and the medical sciences with particular emphasis on graduate medical instruction for the physician in general practice.

Application blanks for space in the Scientific Exhibit are now available and may be obtained by communicating with the Director, Scientific Exhibit, American Medical Association, 535 N. Dearborn Street, Chicago 10, Illinois.



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Steady hands, unwavering eyes... he needs them now. Never mind the bombs and shrapnel. Every case an "emergency"... an endless strain, a withering grind. But today's army field surgeon can take it. Like the men at the guns he seldom relaxes, but when he does, you can be sure he appreciates a cheering smoke.

Add to his cheer. Send a carton of Camels ... a token of your personal appreciation for his sacrifices. Remember—Camel is first choice in the armed forces* ... for mildness, better taste. See your dealer today.



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New reprint available on cigarette research—Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.



NEWS FROM THE WAR FRONT

SALAAMS FROM INDIA

November 15, 1943

Greetings from the 48th. Still at APO 628 and doing a swell job.

Recent happenings. Capt. Vincent Zecchino recently got his gold leaves and is now Major Zecchino. John Dillon, William Fischer and D. Baronian also got moved up a peg and are now Captains. Among the nurses, Mae Luby and Anna MacIntosh are now First Lieutenants. Expect a few more soon, but that is all for now. Lt. Col. Herman Lawson is now Commanding Officer having relieved Lt. Col. William Mahoney who is on his way back to the states. Major Arthur Martin and Captain Frank Holland are already back in the U. S. A. The rest of the unit are well and doing plenty of work.

The entire outfit expects to get together sometime in December and carry on in full.

Greetings to the Society for a Merry Christmas and a very Happy New Year.

MAJOR EDWARD G. MELVIN

(Lt. Col. William Mahoney is now in Georgia, and Major Arthur Martin and Captain Frank Holland are stationed in Texas.—THE EDITORS.)

RECORDED FOR POSTERITY

When the records of the war are finally written we are certain that the part played by the doctors—and particularly Rhode Island doctors—will take prominence in the reporting. Evidence of this has been forecast already, and we note with interest the latest war story on the Aleutians campaign which speaks of the outstanding leadership of our Major Richard E. Haverly, MC. Written by Howard Handleman, the book "Bridge to Victory" relates the experiences of the expedition against the Japs on Attu Island, where at Red Beach Major Haverly was commended with his command for "exceptionally meritorious service." The work of the field hospital under Dr. Haverly continued to function with marked efficiency, according to the report, and "often under enemy shell fire the personnel of this organization accomplished their mission of caring for the wounded and sick in a most creditable manner. Their efforts undoubtedly saved many lives and will return many soldiers to combat service who might otherwise have been lost or permanently incapacitated."

MAJOR PIANKA TAKES COMMAND

Thus read the headlines of THE SICK CALL, a mimeographed weekly newspaper we received recently from the South Pacific war front. A former intern at the Homeopathic hospital here, and a one time football star at Providence College, Dr. Pianka enlisted early in 1941 with the rank of lieutenant. In June of that year he was named commander of a newly organized ambulance company of the regiment then stationed at Camp Blanding. Since going overseas he has been advanced to the rank of Major. Prior to assuming his new command as head of a medical battalion, effective October 26 Major Pianka was division medical inspector, a post that has been filled by Lt. Col. Charles V. Snurkowski, MC, who led the battalion throughout the Munda campaign.

AT SEA — AND OVERSEAS

From Lieut. William Tully, MC, USNR, comes word that following his indoctrination period at Portsmouth Navy Yard this summer he was assigned to a newly commissioned ship at Boston on October 19, and he is now on sea duty. News of his election to the Society as an active member and receipt of the JOURNAL provided him with a close touch with the homefront. . . . From Captain Richard S. Arlen, MC, comes word that he is "somewhere in England, attached to a Reconnaissance flight squadron as a flight surgeon . . . having our share of the excitement . . . and looking forward to the day when I will be home once again."

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MEDICAL LIBRARY NOTES

COMMITTEE ON THE LIBRARY:
Herbert G. Partridge, M.D.; Samuel Adelson, M.D.; Adolph W. Eckstein, M.D.

THE Librarian of the Rhode Island Medical Society Library announces the recent addition of the following books:—

AUTOBIOGRAPHY

Fred H. Albee—A Surgeon's Fight to Rebuild Men. N. Y., 1943. Davenport Collection.

COMMUNICABLE DISEASES

Gaylord W. Anderson & Margaret G. Arnstein —Communicable Disease Control. A Volume for the Health Officer and Public Health Nurse. N. Y., 1941.

MEDICINE, history of

C. D. Haagensen & Wyndham E. B. Lloyd—A Hundred Years of Medicine. N. Y., 1943.

REHABILITATION

William B. Doherty & Dagobert D. Runes, editors—Rehabilitation of the War Injured. A Symposium. N. Y., 1943.

BOOK REVIEW

A HUNDRED YEARS OF MEDICINE by C. D. Haagensen and W. E. B. Lloyd, Sheridan House.

Physicians should know more of their background. The many details of subject matter that they are forced to cram into the tablets of their mind undoubtedly make it difficult for them to pay much attention to history. And it is to be feared that they are occasionally like the one who told us, "All I have time for are surgery, golf and bridge."

This book should encourage these harassed individuals to become acquainted with the stories of the development of medicine, such a large part of which has occurred in modern times.

The American author, Dr. Haagensen of the Presbyterian Hospital, in New York has said that his part has been written with the medical student primarily in view. It is safe to say that older physicians would be reminded pleasingly of much that they had only vaguely been aware of, many incidents would be news to most of us and the laity would find it usually easy and engrossing reading.

Dr. Haagensen remarks in the preface that meat is always better with a little sauce. He doesn't share our reminiscent enthusiasm for the essential flavor of rare roasts and steaks; but these are of course all made dishes and he has put them together with the skill of a French chef.

The first short chapter tells us of medicine from antiquity to the 18th century. Enough for all except the historically minded who can find it excellently treated elsewhere. The next 50 pages are devoted to the 18th century and give us the background from which we can measure our advances. They killed and cured then largely as they had for centuries. What a tremendous progress from their pitiful little armies with their blunderbusses, and their doctors purging and puking, to our millions of men today with machine guns and block busters and our physicians with insulin and sulfa drugs.

After this setting of the stage the action begins and most of the remaining book consists of a series of sketches divided rather arbitrarily under medicine and surgery.

Short chapters tell of the development leading to Virchow's cellular pathology; Otto Folin's physiological chemistry tests and Rontgen's discovery of x-rays; Pasteur's and Koch's work; the improvements in modern hygiene and the developments of vaccines, sera, etc. Then a few striking subjects are selected and discussed, as chemotherapy, liver and insulin therapy and the advances in cardiology. The authors disclaim any attempt to be comprehensive. As Dr. Haagensen speaks of adding features peculiar to the American scene we are mildly surprised that the dramatic tale of

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Have You Any Library Books?

The library reports that some of its books issued on loans to physicians have not been returned promptly. Renewals are permitted for any book, but the request is made that all publications be returned to the Library so that they may be made available to all members of the Society.

At the present time many volumes out on loan should be returned.

Also, the Librarian is seeking the return of the following two periodicals:

Archives of Neurology and Psychiatry, March
War Medicine, February, 1943



C. T.

CHOLA-K

S. C. YELLOW

Indications

- Primary Dietary Deficiency of Vitamin K
- Obstructive Jaundice
- Hemorrhagic state associated with Primary Hepatic Disease
- Hemorrhagic conditions of Ulcerative Colitis, Sprue and Celiac Disease
- Hypoprothrombinemia of the Newborn

References

AGGELER, P. M. and LUCIA, S. P.: The Bleeding Tendency in Diseases of the Liver and Biliary Passages, Acta Medico Scandinavica, 107:179 May 1941.

TOWNSEND, STUART R. and MILLS, EDWARD S.: The use of Vitamin K and Bile Salts in the prevention and contral af the Hemorrhagic Diathesis in Obstructive Jaundice, Canadian Medical Association Journal, 41:111 August 1941.

ABBOTT, W. E. and HOLDEN, W. D.: Hypaprothrombinemia in Intestinal Disorders, American Journal af Surgery, 53:215 August 1941.

TOWNSEND, STUART R. and MILLS, Edward S.: Hemarrhagic Tendency Assaciated with Prothrombin Deficiency and its treatment with Vitamin K and Bile, Canadian Medical Association Journal, 42:541 June 1940.

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WOMEN IN INDUSTRY

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physician's responsibility but should be referred to the family physician. It is the plant physician's responsibility, however, to insist that the worker attend to her health by a monthly visit to her family physician or to some prenatal clinic of her own choosing. Pregnant women should also be given sufficient time off previous to delivery in order that she may be able to go through the period of parturition with a minimum amount of disturbance.

It should also be ascertained that the pregnant woman is not exposed to occupational hazards and that she be not employed on a shift between twelve midnight and six A. M. in the morning nor be employed for more than eight hours a day or forty-eight hours a week. Preferably her hours should be reduced to forty hours per week. In the opinion of some writers it is necessary that pregnant women have two ten minute rest periods during the work shift at which time she may have an opportunity for securing additional nourishment as desired. Naturally, occupations that require heavy lifting or other heavy work should be barred from pregnant women also occupations involving continuous standing and moving about. Exposure to toxic substances such as aniline, benzol, toluol, carbon disulphide, carbon monoxide, chlorinated hydrocarbons, lead and its compounds, mercury and its compounds, nitrobenzol and other nitro compounds, phosphorus, radio-active substances, x-rays, turpentine, and other toxic substances should be avoided.

After delivery all women should be granted an extension of at least two months' leave of absence. If complications of delivery or of post-partum period develop a woman should be granted a reasonable amount of time beyond this period upon presentation of a certificate from her attending physician.

NOVEMBER MEETING

A joint meeting of the Rhode Island Society of Industrial Physicians and Surgeons and the Industrial Nurses Club was held at the Rhode Island Medical Library on November 16. Following separate business meetings the groups assembled in the auditorium to hear talks by Mr. Mortimer Newton, chairman of the Rhode Island Unemployment Compensation Board, and Dr. Stanley Sprague of Pawtucket.

Mr. Newton reviewed the work of the Unemployment Compensation Board in the administration of the R. I. Cash Sickness Act, and answered questions raised relative to the medical operation of the program.

Speaking on the "Management of an Industrial Medical Department, Dr. Sprague gave a very thorough exposition of the ideal medical arrangement in industry, even to consideration of architectural details. He advocated rubber-tiled flooring, pastel-colored walls, sound-proof and enclosed examining rooms, separate toilets for men and women, white and black curtains for the windows, hot and cold running water, open plumbing, hospital beds, a stretcher, and the complete detailed medical equipment necessary to care adequately for the needs of the plant involved.

He also insisted on first aid training for nurses and for the prompt and courteous care of the patient on the first and every subsequent visit.

TUBERCULOSIS RECORD CARD

Printed below is the form for the new tuberculosis case record card to be submitted by physicians henceforth. The new form, simplified for the convenience of the doctor, and yet complete as to essential information for compiling vital statistical data, has been prepared by the Division of Preventable Diseases in cooperation with the Committee on Tuberculosis of the State Medical Society.

DEPARTMENT OF HEALTH
Division of Preventable Diseases
Tuberculosis Case Record

Name.....
Address.....
Occupation.....
Age..... Sex..... Color.....
City.....
Marital status.....

FORM OF DISEASE

Pulmonary
Other forms
Pleurisy

X-ray suggests:	Symptoms suggest:
Activity	Activity
Inactivity	Inactivity
Doubtful activity	Doubtful activity

Sputum examination
Private Physician:
Consulting Physician:

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BOOK REVIEW

continued from page 313

Beaumont and Alexis St. Martin with its fascinating local color is not included.

In the 14 chapters devoted to surgery America makes a good showing with McDowell's ovariotomy, the discovery of anesthesia, Holmes' paper on puerperal sepsis, which certainly considerably antedated that of Semmelweiss, Fitz's work on appendicitis and Harvey Cushing's magnificent development of neurosurgery. We wonder why the story of nursing comes under surgery—the answer presumably is, why not, it had to be put in somewhere. All these tales are delightfully told. It is too bad that many had to be left out.

There is one decidedly queer thing about this volume. With a wealth of interesting illustrations it was apparently left to the book binder to insert these entirely by chance. Opposite the discussion of x-rays is a caricature of Virchow, while a portrait of Rontgen faces louse born diseases; the yellow fever mosquito graces the story of vitamins. With the exception of Robert Koch's portrait not a picture is associated with its adjacent subject matter.

The last 50 pages are devoted to the New Social Aspects of Medicine. Beginning with the 18th century when a Foundling Asylum had only 45 infants survive from over 10,000 and even Queen Anne lost all of her 18 children we now can, out of 1,000 children raise all but 35 to the open age for shooting them,—18 years. The development in medical schools and medical centers is graphically pictured as well as the methods by which patients records are now followed allowing the evaluation of our work. Specialization, group practice, the price of medical care and medical insurance are taken up briefly with the citation of some figures. The author has refrained from taking a decided stand on the question of socialization associated with the discussion of these matters and the reviewer will join in that refrain.

This is a delightful book giving an excellent impression of the development and state of modern medicine. Once again we urge its reading.

PETER PINEO CHASE, M.D.

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Providence Association Nominations

In accordance with Section 8 of the By-Laws of the Association which reads in part:

". . . it (the executive committee) shall act as a nominating committee and present at the meeting next preceding the Annual meeting a list of officers to be elected at the Annual meeting. Any counter nominations from the Association must be in writing signed by ten members of the Association, and delivered to the Secretary at least ten days prior to the Annual meeting . . ."

The Executive Committee hereby submits the following recommendations to be voted upon by the membership at the Annual Meeting on Monday, January 3, 1944:

Office	*Candidate Proposed*
President	Albert H. Jackvony, M.D.
Vice President	B. Earl Clarke, M.D.
Secretary	Frank W. Dimmitt, M.D.
Treasurer	Herbert E. Harris, M.D.
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Henry E. Utter, M.D.
Antonio D'Angelo, M.D.
George Davis, M.D.

BOOK REVIEW

HOLT'S CARE AND FEEDING OF CHILDREN by L. Emmett Holt, Jr., M.D. Appleton-Century.

The revised 1943 edition of Holt's "Care and Feeding of Children" which has just been published brings up to date all the latest ideas on this subject.

The method used of placing a question, which might well be asked by a mother, at the head of a paragraph, and then answering it in simple terms which a layman can easily understand, is an excellent way of solving most of the simple problems of health and disease which worry parents.

The inclusion of the latest feeding routine, the care of children in illness, and the section on behavior problems is especially valuable because of the shortage of physicians due to the war and the high nervous tension under which both parents and physicians are laboring.

This book may be recommended to parents with confidence. It will aid them in taking intelligent care of their infants and children.

R. M. LORD, M.D.

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*Himes, *Medical History of Contraception*

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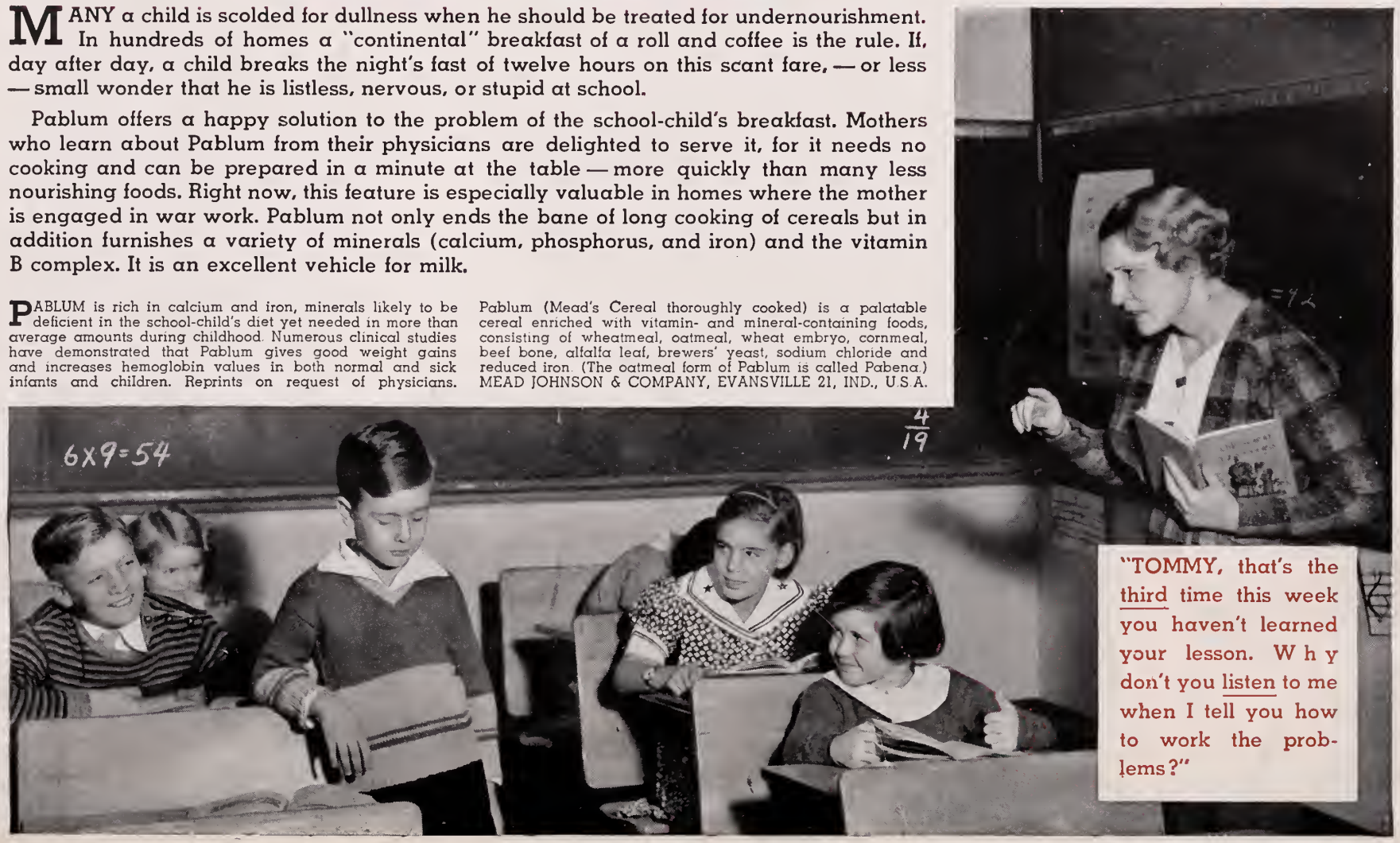
a Poor Scholar . . . because of a Poor Breakfast

MANY a child is scolded for dullness when he should be treated for undernourishment. In hundreds of homes a "continental" breakfast of a roll and coffee is the rule. If, day after day, a child breaks the night's fast of twelve hours on this scant fare, — or less — small wonder that he is listless, nervous, or stupid at school.

Pablum offers a happy solution to the problem of the school-child's breakfast. Mothers who learn about Pablum from their physicians are delighted to serve it, for it needs no cooking and can be prepared in a minute at the table — more quickly than many less nourishing foods. Right now, this feature is especially valuable in homes where the mother is engaged in war work. Pablum not only ends the bane of long cooking of cereals but in addition furnishes a variety of minerals (calcium, phosphorus, and iron) and the vitamin B complex. It is an excellent vehicle for milk.

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The New York Academy of Medicine

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